I: State Information

State Information

Plan Year

Start Year:
2014

End Year:
2015

State SAPT DUNS Number

Number
7808714300

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name
Missouri Department of Mental Health

Organizational Unit
Divison of Behavioral Health

Mailing Address
PO Box 687

City
Jefferson City

Zip Code
65102-0687

II. Contact Person for the SAPT Grantee of the Block Grant

First Name
Mark

Last Name
Stringer

Agency Name
Missouri Department of Mental Health

Mailing Address
PO Box 687

City
Jefferson City

Zip Code
65102-0687

Telephone
573-751-9499

Fax
573-751-7814

Email Address
mark.stringer@dmh.mo.gov

State CMHS DUNS Number

Number
7808714300

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name

Missouri Department of Mental Health

Organizational Unit

Divison of Behavioral Health

Mailing Address

PO Box 687

City

Jefferson City

Zip Code

65102-0687

II. Contact Person for the CMHS Grantee of the Block Grant

First Name

Mark

Last Name

Stringer

Agency Name

Missouri Department of Mental Health

Mailing Address

PO Box 687

City

Jefferson City

Zip Code

65102-0687

Telephone

573-751-9499

Fax

573-751-7814

Email Address

mark.stringer@dmh.mo.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

8/30/2013 11:44:58 AM

Revision Date

7/25/2014 12:18:44 PM

V. Contact Person Responsible for Application Submission

First Name

Mark

Last Name

Stringer

Telephone

573-751-4942

Fax

573-751-7814

Email Address

mark.stringer@dmh.mo.gov

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Keith Schafer
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: _____

Footnotes:

GOVERNOR OF MISSOURI

JEFFERSON CITY
65102

JEREMIAH W. (JAY) NIXON
GOVERNOR

P.O. Box 720
(573) 751-3222

August 23, 2010

Barbara Orlando, Grants Management Officer
Division of Grants Management
Office of Program Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

I hereby delegate authority to the Director or in his/her absence Deputy Director of the Missouri Department of Mental Health to sign funding agreements and certifications, provide assurances of compliance to the Secretary and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment (SAPT) Block Grant and Annual Synar Report until such time as this delegation of authority is rescinded.

Sincerely,

Jeremiah W. (Jay) Nixon
Governor

GOVERNOR OF MISSOURI

JEFFERSON CITY
65102

JEREMIAH W. (JAY) NIXON
GOVERNOR

P.O. Box 720
(573) 751-3222

August 26, 2009

Barbara Orlando
Grants Management Specialist
Substance Abuse and Mental Health Services Administration
Division of Grants Management, OPS
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms. Orlando:

I hereby designate Keith Schafer, Ed.D., Director of the Missouri Department of Mental Health, to sign funding agreements and certifications, provide assurances of compliance to the Secretary of Health and Human Services, and perform similar acts required for the administration of the Community Mental Health Services Block Grant, until such time as I may modify or rescind this designation.

Sincerely,

Jeremiah W. (Jay) Nixon
Governor

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

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Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Keith G Baker
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: 6/9/15

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance wit h 45 CFR Part 76.

2. Certification Regarding Drug- Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph, regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management

Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517- D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Sub mission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Keith Schafer
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

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Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Keith Schafer
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: 5/9/13

Footnotes:

Chief Executive Officer's Funding Agreements (Form 3) - [SA]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee: Keith Schafer

Title: Department Director

Signature of CEO or Designee[1]: _____ Date: _____

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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Name of Chief Executive Officer (CEO) or Designee

Title

Signature of CEO or Designee[1]: Date: 3/9/13

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

Chief Executive Officer's Funding Agreements (Form 3) - [MH]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart I of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee	Keith Schafer
Title	Department Director

Signature of CEO or Designee[1]: _____ Date: _____

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart I of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
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Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
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Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee

Title

Signature of CEO or Designee[1]: Date: 8/9/13

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	Keith Schafer
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	Keith Schafer
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: 5/9/13

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

Missouri's Behavioral Health System of Care

Overview and structure

With a population of about six million people, Missouri provides a rich diversity of rural and urban landscapes. The state has 114 counties plus the city of St. Louis. Approximately 84 percent of the population is Caucasian, 11.7 percent are African-American, 1.7 percent are Asian, and 3.9 are of other race. About 3.5 percent of the state's population is Hispanic (U.S. Census Bureau, 2012). Large populations of African-Americans are present in the state's metropolitan areas of St. Louis and Kansas City as well as the rural southeast "Bootheel" area. The state's largest Hispanic population is in the Kansas City area. Although the state does not have any federally recognized tribes, small populations of Native Americans make their home near the Oklahoma border. Missouri has two major military installations – Whiteman Air Force Base (population: 2,556) in west central Missouri and Fort Leonard Wood (population: 15,061) in south central Missouri. Approximately 543,000 Missouri residents are veterans (Missouri Department of Public Safety, 2012).

At $249 billion, Missouri's Gross State Product (GSP) in 2011 ranked 23rd among states. The GSP consists of 52 percent Services; 18% retail, wholesale, utilities, and transportation; 13% government; 12% manufacturing; 3% construction; and 2% agriculture and mining (Missouri Department of Economic Development, 2012). Although agriculture makes up a relatively small portion of the state's GSP, it represents an important economic sector for the state – particularly for rural Missouri. Issues that have challenged the state in recent years include the most recent economic recession and severe weather (EF5 tornado hitting Joplin in May 2011; flooding in Southeast Missouri in 2011; and extreme drought in 2012). As of November 2012, the state's unemployment rate stood at 6.7 percent which is lower than that for the country as a whole (7.7%) (U.S. Bureau of Labor Statistics, 2012). Missouri has 30 counties plus the city of St. Louis that are designated as high-poverty counties (i.e. poverty rates of 20 percent or more) by the U.S. Department of Agriculture (USDA Economic Research Service, 2012). Most of these counties are located in the southern portion of the state.

The Missouri Department of Mental Health (DMH) is one of sixteen state agencies under the executive branch of state government. DMH collaborates on initiatives with other state agencies including the Departments of Corrections (DOC), Transportation, Elementary and Secondary Education (DESE), Health and Senior Services (DHSS), Public Safety (DPS), and Social Services (DSS). DSS is the Medicaid authority for the state. DMH's close, collaborative relationships with DOC and DSS, in particular, are strengths to the state's behavioral health system. The principal missions for DMH as established in state law are to: 1) prevent mental disorders, developmental disabilities, substance abuse, and compulsive gambling; 2) treat, habilitate, and rehabilitate Missourians who have these conditions; and 3) improve the public understanding and attitudes about mental disorders, developmental disabilities, substance abuse, and compulsive gambling. DMH has representation on various interagency groups including:

- Council for Adolescent School Health;
- Missouri Coordinated School Health Coalition;
- Stakeholders Advisory Group;
- Child and Family Services Review Advisory Committee;

- Children's Division Recruitment and Retention Workgroup;
- Missouri Alliance for Drug Endangered Children;
- Juvenile Crime Enforcement Coalition for Missouri School Violence Hotline;
- Task Force on the Prevention of Sexual Abuse of Children;
- Comprehensive System Management Team (for state agencies providing services to children);
- Missouri HIV/STD Prevention Community Planning Group;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Children in Nature Committee (to increase education about nature and positive experiences with the outdoors);
- Missouri Behavioral Health Epidemiology Workgroup;
- Show Me Response (disaster & emergency coordination);
- Missouri Reentry Process Steering Team;
- MO HealthNet (Medicaid) Managed Care Quality Assurance & Improvement Advisory Group;
- Mo HealthNet (Medicaid) Behavioral Health Committee for Health Care Reform
- Missouri Alliance to Curb Problem Gambling;
- Midwest Consortium on Problem Gambling and Substance Abuse Committee;
- Mental Health and Aging Workgroup;
- Governor's Committee to End Homelessness;
- Smoking Cessation Planning Workgroup;
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Missouri Drug Court Coordinating Commission;
- Governor's Faith-based and Community Service Partnership for Disaster Recovery;
- Maternal, Infant and Early Childhood Home Visiting Program State Steering Committee;
- Missouri Prevention Partners Coalition; and the
- Mental Health First Aid Advisory Council.

Historically, DMH has had the Divisions of Alcohol and Drug Abuse (ADA), Comprehensive Psychiatric Services (CPS), and Developmental Disabilities (DD). In January 2013, ADA and CPS integrated into a new division: the Division of Behavioral Health (DBH). The Department's supportive offices include the Offices of Deaf Services, Constituent Services, and Disaster Services. Issues that have challenged the state's behavioral health system in recent years include reductions in federal and state funding for behavioral health services and preparation for post-2013 implementation of the Affordable Care Act. In November 2012, Missouri voters approved a measure that prohibits the Governor or any state agency from establishing or operating a state-based health insurance exchange without legislative or voter approval. At this time, it is unknown if Missouri will expand Medicaid coverage to 138% of the federal poverty level.

The director of the Department of Mental Health (DMH) is appointed by the Missouri Mental Health Commission and confirmed by the state Senate. Comprised of seven members appointed by the Governor, the Mental Health Commission serves as the principal policy advisory body to the department director. The Commission, by law, must include an advocate of community mental health services, a physician who is an expert in the treatment of mental illness, a physician concerned with developmental disabilities, a member with business expertise,

an advocate of substance abuse treatment, and a citizen who represents the interests of consumers of developmental disabilities services. Each of the DMH divisions report progress on identified performance measures to the Mental Health Commission on a quarterly basis.

The Department Director appoints the division directors. The director of the Division of Behavioral Health (DBH) is responsible for leading and managing the DBH division; directing policy and strategic plans for DBH; coordinating with other state officials; and representing DBH in discussions, negotiations and partnerships with other state and federal organizations. DBH is organized into the following functional units:

- Community Programs,
- Psychiatric Facility Operations,
- Children's Services,
- Recovery Services,
- Prevention and Mental Health Promotion,
- Administration, and
- Regional Operations.

Community Programs

Included under Community Programs are all mental health and substance abuse community-based treatment programs, the Substance Abuse Traffic Offenders' Program (SATOP), Healthcare Homes, certification, utilization review, and fidelity review. In addition to leading and managing these programs, the Director of Community Programs is also responsible for working with key stakeholders, to include other state agencies, to improve community-based services. In 2012, the Department of Mental Health (DMH) hired a Project Manager to oversee behavioral health services for Missouri's veteran population. The Division of Behavioral Health (DBH) contracts with 65 community-based agencies for the provision of substance abuse treatment and/or psychiatric rehabilitation services: 36 for substance abuse treatment only, 15 for psychiatric rehabilitation services only, and 14 for both. The certification standards of care contain core rules, adopted in 2001, which apply to both mental health and substance abuse programs. DBH staff conduct annual reviews of contracted community organizations. DBH certifies 96 organizations for substance abuse treatment, 26 organization for substance abuse prevention, and 49 organizations for mental health treatment.

The Department of Mental Health's (DMH) value statement specifies that "Missourians participating in mental health services are valued for their uniqueness and diversity and respected without regard to age, ethnicity, gender, race, religion, sexual orientation, or socioeconomic condition" (DMH, 2008). Core standards require that services be delivered in a manner that is responsive "to each individual's age, cultural background, gender, language and communication skills, and other factors, as indicated" (9 CSR 10-7.010). In addition, programs that provide meals must have a written plan to ensure that menus are responsive "to cultural and religious beliefs of individuals" (9 CSR 10-7.080). DMH requires through contract language that contractor staff be competent in the cultural, racial, and ethnic patterns of the geographic area being served. Interpreting services are provided to individuals in treatment whose preferred language is a language other than spoken English. DMH's Office of Deaf Services (ODS) is responsible for consultation and technical assistance to DMH facilities and contracted providers delivering behavioral health services to eligible individuals who are deaf, hard of hearing or from

cultural minority groups. The ODS also establishes minimum competencies for behavioral health interpreters, consistent with the federal Culturally Linguistically Appropriate Services Standards. Client complaints and grievances received either by DMH's Office of Constituent Services or by the provider organization are reviewed by DMH clinical staff for issues with cultural competency. DMH's information system collects data on client characteristics including race, ethnicity, preferred language, hearing status, and gender identity (ISO 5218). Such data is aggregated by geographical areas for analysis. DMH is a provider of cultural competency trainings for the state's behavioral health and prevention workforce. Cultural competency training is included in DMH's annual Spring Training Institute which is attended by approximately 800 behavioral health and human service professionals.

All individuals needing behavioral health services from facilities operated by the Division of Behavioral Health (DBH) or contracted service providers receive an initial assessment. For adults (age 18 or older) needing substance abuse treatment, the Addiction Severity Index is used facilitate the determination of level of care and treatment planning. The individual's structured interview is completed by a Qualified Substance Abuse Professional (QSAP). The ASI tool is integrated into the Department's information system. Substance abuse treatment providers have the option of implementing the client-administered ASI-MV. For adolescents needing substance abuse treatment, the Global Appraisal of Individual Needs (GAIN) or a comparable instrument approved by DBH is used to complete diagnosis, placement, and individualized treatment planning. For individuals seeking services from the SATOP program, the self-administered Driver Risk Inventory II (DRI-II), in conjunction with an individualized interview with a QSAP, determines the level of program placement. For individuals needing mental health treatment, the Daily Living Activities (DLA-20) functional assessment tool has recently been implemented for youth and is in the process of being implemented for adults. The DLA-20 measures what daily living areas are impacted by mental illness or disability and has modules for adults age 18 or older with SMI and for youth age 6 to 18.

DBH substance abuse treatment programs include the Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for Women and Children (12 contracts), the General Population (41 contracts), the Opioid Program (3 contracts and 1 state-operated facility), and Adolescents (16 contracts). DBH's CSTAR programs are the only substance abuse treatment programs reimbursable by Medicaid in the state. The CSTAR programs offer a flexible combination of clinical and supportive services that vary in duration and intensity depending on the needs of the client. All but the Opioid programs offer a residential component for individuals needing that type of structure and support. Available services include assessment; individual and group counseling; group education; community support; residential or housing support, as appropriate; trauma-specific individual counseling and group education; individual co-occurring disorders counseling; family therapy; and medications, physician and nursing services to support medication therapy. In addition, families can also participate in individual and group codependency counseling. The Opioid programs provide outpatient services to individuals addicted to opiates and include the dispensing of clinically appropriate medications, primarily methadone, to prevent withdrawal and/or relapse. A designated Program Specialist, acting as the State Opioid Treatment Authority (SOTA), provides oversight and clinical assistance to the Opioid programs to ensure that treatment is consistent with best practices and federal requirements. In 2011, DBH was successful in amending the Medicaid

state plan to include a CSTAR Modified Medical Detoxification Program (6 contracts). DBH also maintains the Primary Recovery Plus (PR+) program (21 contracts). Modeled after the CSTAR General Population Program, PR+ offers a full continuum of services within multiple levels of care to assist those individuals without Medicaid coverage. DBH oversees several programs designed specifically for Department of Corrections' offenders under community-supervision who need substance abuse treatment. These include a CSTAR Women and Children Alternative Care (2 contracts), Community Partnership (1 contract), and Free N Clean (2 contracts). As established in contracts, priority populations for substance abuse treatment include:

- Women who are pregnant;
- Intravenous (IV) drug users who have injected drugs in the prior 30 days;
- Civil involuntary commitments;
- High risk offenders referred by the Department of Corrections' institutions and Division of Probation and Parole via referral form and protocol;
- Applicants and recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, Family Support Division, via referral form and protocol; and
- Adolescents and families served through the Children's System of Care.

All contracted agencies providing substance abuse treatment are required to screen individuals requesting services to determine potential eligibility as a priority population and/or a crisis situation. Individuals identified as a priority population who request or are referred to treatment must be assessed and admitted to an appropriate level of care within 48 hours of initial contact or scheduled release date, whichever is later. Otherwise, the provider must initiate interim services. Pregnant women and civil involuntary commitments, however, require immediate admission. Pregnant women are to be referred to a CSTAR Women and Children's Program unless there is clinical justification to admit her to a general treatment program. Billable interim services for IV drug users include HIV/TB test counseling, motivational interviewing, group education, and recovery support services accessed through the Access to Recovery III (ATR III) Program.

DBH's SATOP program serves more than 30,000 DWI offenders annually who are referred as a result of an administrative suspension or revocation of their driver's licenses, court order, condition of probation, or plea bargain. SATOP is, by law, a required element in driver license reinstatement by the Department of Revenue. The mission of SATOP is to: A) inform and educate DWI offenders as to the hazards and consequences of impaired driving; B) promote safe and responsible decision-making regarding driving; C) motivate for personal change and growth; and D) contribute to the public health and safety of Missourians. DBH certifies and monitors SATOP programs which offer varying levels of care. All SATOP consumers receive an assessment by an Offender Management Unit to determine the level of intervention required. The levels of service include: a 10-hour education course (level 1), a 20-hour intervention course consisting of intensive education and group counseling (level 2), a 50-hour outpatient counseling program for adults or a 25-hour program for youth (level 3), and traditional treatment (level 4). The Serious and Repeat Offender Program (SROP) (level 4) has been designed for chronic DWI offenders and consists of at least 75 hours of treatment in no less than 90 days. The SROP

programs have referral agreements with the state's 41 DWI courts/hybrid courts approved by the Drug Court Coordinating Commission. SATOP is largely funded by offender fees.

Core services for the Division of Behavioral Health's (DBH) Community Psychiatric Rehabilitation Program (CPR) (29 contracts), targeted case management (20 contracts), and supported community living (303 contracts) are provided in a community-based and consumer-centered manner. Services provided in DBH's Community Psychiatric Rehabilitation Program (CPR) for adults (29 contracts) and youth (21 contracts) are Medicaid reimbursable. The types of services provided in the CPR program include evaluation, crisis intervention, community support, medication management, and psychosocial rehabilitation. Outpatient community-based services provide the least-restrictive environment for treatment. Day treatment offers the least-restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than that provided in outpatient services but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services, and education services. Moderate-term placement in residential care provides services with non-acute conditions who cannot be served in their own homes. Individuals whose psychiatric needs cannot be met in the community and who require 24-hour observation and treatment are placed in inpatient treatment. These services are considered appropriate for persons who may be a danger to themselves or others as a result of their mental disorder. DBH also oversees Community Mental Health Treatment (CMHT) (23 contracts) for Department of Corrections' (DOC) offenders under community supervision and who have mental illness. Target populations for mental health treatment include:

- Forensic clients pursuant to Chapter 552 RSMo;
- Adults, children, and youth with serious mental illness (SMI) being discharged from DBH operated inpatient facilities, being transitioned from DBH-operated or contracted residential settings, being transitioned from DBH alternatives to inpatient hospitalization;
- Adults, children, and youth at risk of homelessness;
- Children and youth referred through the Custody Diversion Protocol;
- Individuals with a clinical or personality disorder, other than a principal diagnosis of substance abuse or mental retardation, who also qualify as an adult with severe disabling SMI or children and youth with serious emotional disturbance (SED), as defined by the Department.

DBH supports Assertive Community Treatment (ACT), a service-delivery model that provides comprehensive, community-based treatment to people with serious and persistent mental illnesses who: 1) are high users of inpatient beds, 2) often have co-occurring alcohol and drug diagnoses, 3) have involvement with the criminal justice system, and/or 4) are homeless. ACT provides highly individualized, intensive services directly to consumers in their homes and communities as opposed to a psychiatric unit. ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. DBH contracts with six agencies to provide ACT.

For mental health treatment, the state is divided into 25 mental health service areas each with an administrative agent. These administrative agents are responsible for the assessment and provision of services either directly or through affiliate Community Mental Health Centers

(CMHC) for individuals residing in the assigned service areas. The Administrative Agents are also required to have cooperative agreements with the state-operated inpatient hospitals and are responsible for the provision of follow-up services for persons released from the state hospitals. Of the 29 CMHC's, 27 are also contracted for Health Homes which was implemented in January 2012 and coordinated by the Department's Medical Director. For substance abuse treatment, individuals access services directly from the contracted service provider and may seek services anywhere in the state regardless of their county of residence. DBH funds ten regional Access Crisis Intervention Hotlines that are staffed by mental health professionals 24 hours per day and 7 days per week to provide intervention and referral for persons experiencing a behavioral health crisis. DBH has arrangements with local taxing authority boards who have a Mental Health Mil tax or Children's Services tax to fund mental health services for adults (3 counties plus the city of St. Louis) and youth (4 counties) and substance abuse treatment for adults (4 counties) and youth (2 counties plus the city of St. Louis). Five regional offices provide consultation and technical assistance to community-based service providers and conduct regular reviews of provider systems.

DBH has implemented several programs to improve coordination of consumers' primary and behavioral healthcare. Disease Management 3700 started as a two-year collaborative demonstration project between DBH and the state Medicaid authority, MO HealthNet. Medicaid eligible individuals with co-occurring chronic medical conditions and serious and persistent mental illness, who are not current consumers of DBH, and who have had a minimum of $30,000 annual Medicaid claims are invited to participate. Persons successfully outreached and engaged through the project are enrolled in a CMHC and assigned a Community Support Specialist. The Disease Management program served as model for Missouri's Health Home initiative. Missouri has two types of healthcare homes: 1) the CMHC's and 2) primary care including the Federally Qualified Health Centers, Rural Health Clinics, and Hospital-Operated Primary Care Clinics. Enrollment in the CMHC Health Homes began in January 2012. Eligible individuals must be covered by MO HealthNet and have 1) a serious and persistent mental illness, 2) a mental health condition and a substance abuse disorder, or 3) a mental health condition or a substance abuse disorder and a chronic health condition. Of those enrolled, approximately 85 percent are adults and 15 percent are children or youth. As a Health Home, the CMHC's provide comprehensive case management, care coordination and health promotion, patient and family support, comprehensive transitional care, and referrals to community and support services.

Psychiatric Facility Operations

Facility Operations includes management oversight of the nine state-operated psychiatric facilities – two children and seven adult hospitals. With limited exceptions, state operated facilities provide intermediate or long term stay inpatient hospital treatment for individuals with complex, treatment resistant mental illness and whose illness, treatment and recovery are complicated with legal issues and constraints. Adult facilities are located in St. Louis, St. Joseph, Fulton, El Dorado Springs, Kansas City, and Farmington. Youth facilities are located in St. Louis and Cape Girardeau. In 2009 and 2010, the Division of Behavioral Health (DBH) closed 4 emergency departments and 210 acute beds. As part of the DBH Inpatient Redesign, community services are being enhanced to include same-day/next-day appointments at CMHC's for individuals discharged from inpatient status, intensive residential options for crisis diversion and step-down, and a crisis stabilization unit in St. Louis. The number of statewide psychiatric beds at the end of FY 2012 was 1,196.

Forensic services provides evaluation, treatment and community monitoring under the order of the circuit courts for individuals with mental illness and developmental disabilities involved in the criminal justice system. DBH provides four levels of security (maximum, intermediate, minimum, and campus), with the desired goal of progressive movement through the security continuum based on clinical condition and risk assessment. Within this continuum, forensic clients are provided treatment in a setting consistent with both the clinical needs of the client and safety of the public. Forensic programs are located at Southeast Missouri Mental Health Center, St. Louis Psychiatric Rehabilitation Center, Northwest Missouri Psychiatric Rehabilitation Center, and Fulton State Hospital. Forensic Case Monitors provide community monitoring, as required by state statute, to forensic clients acquitted as not guilty by reason of mental disease or defect who are given conditional releases by circuit courts. There are approximately 400 forensic clients on conditional release statewide.

Children's Services

Both substance abuse and mental health services for children are coordinated under the Division of Behavioral Health (DBH) Director of Children's Services. Community Psychiatric Rehabilitation (CPR) provides a range of essential mental health services to children and youth with serious emotional disturbances. These community-based services are designed to maximize independent functioning and promote recovery and self-determination. An assigned Community Support Worker monitors medical, dental, and support service needs and coordinates services and resources among community agencies. The CPR program includes an intensive level of care for acute psychiatric episodes as clinically appropriate and provisional admission that allows for up to 90 days time period for a comprehensive evaluation on a youth or child who meet the disability requirement but does not yet meet the diagnostic requirements. If the agency determines that an eligible diagnosis is not applicable, then the individual can be transitioned to an appropriate program and services. Approximately 90 percent of the youth receiving mental health treatment are in the CPR program. Community support services available to children and youth include day treatment, psychosocial rehabilitation services, intensive/non-intensive targeted case management, family support, and family assistance. Day treatment provides goal-oriented therapeutic services focusing on the stabilization and management of acute or chronic symptoms which have resulted in functional deficits. Day treatment may include physician services, psychiatric evaluations, medication management, age appropriate education services, skill building groups, individual and group psychotherapy, occupational/physical therapies, community support, and family support. Psychosocial rehabilitation services are a combination of goal-oriented and rehabilitative services provided in a group setting. Family support helps establish a support system for parents of children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance. With family assistance, a Family Assistant Worker may work with the individual and family on home living and community skills, communication and socialization, and conflict resolution.

Substance abuse treatment for adolescents is provided in the CSTAR Adolescent program. Designed for youth age 12 to 17, the CSTAR Adolescent program offers a full spectrum of treatment services. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Youth in residential settings are offered academic support services to minimize disruptions in their education. For youth with co-occurring mental health and substance abuse disorders, CPR

and CSTAR Adolescent programs will coordinate services. In the CSTAR Women and Children Program, daycare, codependency counseling, and community support services are available to those children whose parent is receiving substance abuse treatment.

The DBH Children's Director works closely with the Department Director's Office who, in partnership with other state departments represented on the Missouri Children's Services Commission, is responsible for overseeing the development and implementation process of a comprehensive system of care for children's mental health services. In addition to the Department of Mental Health (DMH), other state agencies represented on the Children's Service Commission include the Departments of Corrections, Elementary and Secondary Education, Higher Education, Health and Senior Services, Labor and Industrial Relations, Public Safety, and Social Services. The DBH Children's Director provides ongoing consultation to the state's implementation of the federally funded Healthy Transitions program to address transition-age youth residing in Jackson County and have serious emotional disorders.

Implementation of the comprehensive children's system of care was originally guided by the "2004 Comprehensive Children's Mental Health Five Year Plan." The initial plan used a public health model to address four basic goals:

- Families retain custody of children with mental health issues,
- An infrastructure for the system of care is built,
- An array of services and support is developed, and
- Stakeholders are educated.

A custody diversion process was established for child-serving agencies to follow in those cases involving parents who are considering voluntarily relinquishing custody of their child for the sole purpose of accessing mental health care. For those children already in state custody solely for mental health services in the absence of child abuse or neglect and severe mental retardation disability, the Department of Mental Health (DMH) and the Department of Social Services (DSS) have facilitated an evaluation and review process. DSS' Children's Division has established Family Support Teams for children identified to determine future custody status. In conjunction with the diversion protocol, voluntary placement under Title IV-E allows a family to relinquish physical custody but retain legal custody so that these children become eligible for mental health services funded by Medicaid and Title IV-E funds for a period of up to 180 days. The Comprehensive Children's Mental Health Plan and grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) have supported the development of local interagency teams to oversee children's services in the community. Missouri currently has 14 local System of Care (SOC) teams. In addition, the Show Me Bright Futures (SMBF) initiative engages communities to implement a public health model to prevent mental illness. Three pilot sites were established under the SAMHSA-funded Mental Health Transformation Grant. The initiative is being sustained as part of the system of care effort. Funding from Missouri's Children's Trust Fund has provided training and technical assistance in the development and sustainability of local SOC and SMBF teams. Trainings have been conducted with the juvenile justice system on the Comprehensive Children's Mental Health Plan and System of Care both at the state and local levels. The first System of Care conference "Expanding the View; Linking SOC and Public Health" was held in 2012.

In 2012, Professional Parent Home (PPH) services were added to the Community Psychiatric Rehabilitation (CPR) array of services offered to youth. PPH exists to serve youth in a private home whose serious emotional needs lead to behaviors, that in the absence of such programs, they would most likely be placed in restrictive residential or inpatient settings. These youth have demonstrated an inability to be in the community free of emotional or physical difficulty and who, without a sustained intensive therapeutic intervention, would have significant physical, emotional, or relational consequences. PPH providers are responsible for participation in the development of the youth's treatment plan and record documentation related to implementation of the treatment plan within the home. Currently, the Division of Behavioral Health (DBH) is developing a training curriculum for eligible PPH providers.

In 2012, DBH was awarded a SAMHSA-funded Project Linking Actions for Unmet Needs in Children's Health (LAUNCH) Grant to create a coordinated system to support St. Louis City children, ages 0-8, in a supportive environment conducive to healthy development. The five-year grant will use a public health approach emphasizing prevention and promotion. The grant will implement screening and mental health assessment in a range of child-serving settings. The state team includes representation from DBH, the Department of Health and Senior Services, and the Missouri Institute for Mental Health. Grant partners include Vision for Children at Risk, the Council on Young Child Wellness, and the National Council on Alcoholism and Drug Abuse. Boone County (located in central Missouri) was awarded a Project LAUNCH Grant in 2010 to improve coordination of children's services in that county. DBH is represented on the Boone County Project LAUNCH Wellness Council.

Recovery Supports

The Division of Behavioral Health's (DBH) functional area of Recovery Services includes housing, employment, peer services, the Missouri Access to Recovery III program, staff training and development, and coordination of the ADA and CPS state advisory councils. The Director of Recovery Services oversees DBH's housing unit who works to connect homeless individuals who are challenged with behavioral health issues with safe, decent, and affordable housing options that best meet their individual and family needs. In addition to providing education and technical assistance, DBH's housing unit manages 44 U.S. Department of Housing and Urban Development (HUD)-funded Shelter Plus Care Grants that provides rental assistance for individuals who 1) are homeless, 2) have a serious mental illness, a chronic substance abuse problem, a severe and chronic developmental disability, or a diagnosis of HIV/AIDS, 3) are receiving long-term behavioral health support services, and 4) meet the "very low" income requirement. In calendar year 2012, 3,227 persons comprising 1,791 households received supported housing through Missouri's Shelter Plus Care program. Missouri has eleven federally-funded Projects for Assistance in Transition from Homelessness (PATH) grants to support service delivery to adults (age 18 or older) with serious mental illness, as well as those with co-occurring substance abuse disorders, who are homeless or at risk of becoming homeless. Services include community-based outreach; support services such as case management, employment skills training, psychosocial education, and group therapy; and some temporary housing services. Supported community living programs are provided for persons with mental illness who do not have a place to live or who need more structured services while in the community. These programs serve approximately 3,700 individuals annually. Persons in these programs receive support through case management and community psychiatric rehabilitation programs provided by administrative agents. Housing assistance is provided in the SAMHSA-

funded Access to Recovery III program for individuals in treatment and/or recovery from substance addiction. Oxford House, Inc. maintains 48 group homes in the state – many of which had been established with funds from DBH's group home revolving fund that ended in 2011. These self-run, self-supported homes provide a stable, substance-free housing option for individuals recovering from substance abuse (Oxford House, Inc., 2012).

DBH recognizes the tremendous therapeutic value of employment for working-age individuals with behavioral health disorders and is committed to enhancing employment options for those individuals. Supported Employment is an evidence-based practice that provides individualized services and supports to an individual in competitive employment to promote stable employment. DBH received a Johnson and Johnson grant for the provision of technical assistance and fidelity for Supported Employment. Although the grant ended in 2012, fidelity efforts are being sustained. DBH works with the Department of Elementary and Secondary Education, Vocational Rehabilitation (Voc Rehab) who provides job counseling, job-seeking skills, job placement, and vocational training. Voc Rehab annually serves about 4,200 DBH clients receiving mental health treatment and about 3,300 DBH clients receiving substance abuse treatment. DBH also provides support services for mental health clients not currently eligible or ready for services from Voc Rehab. The Department of Mental Health's (DMH) Employment Workgroup has facilitated the development of benefits planning training materials and a web-based tool "Disability Benefits 101". In 2012, DBH staff developed a guidance document on appropriate community support interventions reimbursable under the CSTAR treatment program for consumers pursuing employment (DMH, 2012).

Peer services are available to individuals in mental health treatment to aid in the navigation of Medicaid program and establish linkages to other community resources. Missouri has certified over 160 Peer Specialists some of whom work at Community Mental Health Centers and state-operated hospitals. DBH funds through competitive bid 5 consumer-operated drop-in centers and 5 peer support phone lines that emphasize self-help for individuals with mental illness. These Consumer Operated Service Programs (COSP) use the Fidelity Assessment Common Ingredient Tool (FACIT) as a self-assessment tool to support continuous quality improvement efforts. Missouri was one of seven study sites for SAMHSA's Multi-Site Research Initiative to assess how consumer-operated service programs can, as an adjunct to traditional mental services, improve outcomes of adults with serious mental illness. The Missouri Institute of Mental Health was one of two coordinating centers for this initiative. Family Support Provider is a peer to peer service that provides support to parents/caregivers who have children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance. Peer services are available to individuals in recovery from substance addiction through the SAMHSA-funded Access to Recovery III program. Provided by credentialed Recovery Support Specialists, recovery coaching is the development of a supportive peer relationship to foster recovery-oriented problem solving skills. The recovery coach's role emphasizes reconnection to support systems in the community. Missouri has credentialed 63 Recovery Support Specialists. In 2012, DBH worked with the Addiction Technology Transfer Center Network (ATTC) to bring the Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy to Missouri.

To address recovery from substance addiction, DBH established a network of community-based and faith-based recovery support providers under the SAMHSA-funded Access to Recovery (ATR) I grant implemented in 2005. Under ATR I, over 100 recovery support providers across the state were recruited, trained, and credentialed. With the ATR II grant, Missouri increased focus on the implementation of evidence-based practices, including Motivational Interviewing, the Matrix Model for Intensive Outpatient Treatment, as well as, reducing barriers to service delivery. With the ATR III grant, the state has developed local recovery-oriented systems of care and implemented recovery coordination to sustain longer periods of client engagement. Recovery support services funded under the ATR III program include spiritual counseling, transportation, work preparation, recovery coaching and education, re-entry coordination, peer support, drop-in center, family engagement, and housing. Priority populations for ATR III include Veterans and National Guard soldiers returning from deployment as well as family members and Department of Corrections supervised offenders returning to the community.

At this time, DBH has separate State Advisory Councils (SAC) for substance abuse and mental health. Integration of the two councils will take legislative changes to state statutes. Each SAC is comprised of 25 members who advise and make recommendations to improve the system of care. Meetings typically include budget and programming updates from DBH staff as well as in-depth presentations and discussions on initiatives and strategic planning. Members have professional, research, and/or personal interests in the respective area. Membership on the Substance Abuse SAC must be at least one-half clients and/or family members of clients and have at least one member representing veterans and military affairs. Current membership includes representation from the Missouri National Guard, the Veteran's Administration, the Department of Corrections, the Department of Health and Senior Services, Drug Court, vendors, and people with lived experiences. The Substance Abuse SAC has identified measures to improve communication between the council, citizens, service providers, legislators, and advocates. Additionally, members have produced a position paper, for submission to the DBH Director, providing a comprehensive overview of the complex issues surrounding the legalization of marijuana. Membership on the Mental Health SAC must have a majority of mental health clients and/or family members of clients and also representation from the Departments of Social Services, Medicaid, Corrections, Vocational Rehabilitation, Education, Housing, and Mental Health. The Mental Health SAC has provided oversight in the development of Peer Specialist training and certification model. Since work began to integrate the ADA and CPS divisions, the councils have held joint meetings on the integration process and state planning efforts for a behavioral health system of care. The December 2012 joint meeting reviewed a draft of the FY 2014 – 2015 Block Grant Behavioral Health State Plan.

Prevention and Mental Health Promotion

Prevention and Mental Health Promotion includes substance abuse prevention, suicide prevention, Crisis Intervention Teams (CIT), Mental Health First Aid, tobacco cessation, and tobacco retailer education. The Director of Prevention and Mental Health Promotion is also the project coordinator for the state's FDA tobacco enforcement contract. The Division of Behavioral Health (DBH) subcontracts with the Department of Public Safety, Division of Alcohol and Tobacco Control for enforcement of the federal Family Smoking Prevention and Tobacco Control Act. DBH uses a Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the Missouri's substance abuse prevention

workforce. The STRC, a member of Community Anti-Drug Coalitions of America (CADCA), represents Missouri at national conferences. DBH, in collaboration with the STRC and the Missouri Alliance for Drug Endangered Children, sponsored the 2012 Substance Abuse Prevention Conference attended by about 200 prevention professionals. In addition, the annual Department of Mental Health Spring Training includes a prevention track for training on best practices, emerging issues, and cultural competency. DBH also provides funding to the Missouri Youth/Adult Alliance (MYAA), a statewide coalition that provides resource materials and education to local community efforts focused on underage drinking.

DBH contracts with 11 community-based Regional Support Centers (RSC) that are state-certified to provide prevention services on alcohol, tobacco, and other drug (ATD) issues. The RSC's are the primary source of training and technical assistance support for over 160 community coalitions located throughout the state. The coalitions are teams of volunteers of community leaders, parents, and youth who seek to address substance abuse in their communities. The RSC's employ prevention specialist that serve as community-level experts to assess community needs, build capacity, develop strategic plans, and implement evidence-based prevention programming. The RSC's provide retailer education on state and federal tobacco regulations to local tobacco retailers and assist the state in compiling a list of tobacco retailers in support of federal Synar requirements as Missouri does not have tobacco licensure. DBH also provides funding to Partners in Prevention (PIP), Missouri's higher education substance abuse consortium representing 21 colleges and universities and serving about 161,000 college students. PIP administers the Missouri College Student Health Behavior Survey (MCHBS) to approximately 6,500 students each school year. The RSC's, 20 community coalitions, and PIP were trained in the SAMHSA's Strategic Prevention Framework under the Strategic Prevention Framework State Incentive Grant (2004-2009). In support of prevention planning at the local level, DBH funds the biennial Missouri Student Survey (MSS) to assess substance use and related behaviors among students in grades 6 through 12. In 2012, approximately 140,000 students participated in the MSS.

DBH's School-based Prevention, Intervention, and Resources Initiative (SPIRIT) implements school-based curricula of proven effectiveness for reducing substance use, preventing substance initiation, and reducing violent behavior among children in kindergarten through 12th grade. Age- and grade-appropriate programs are selected from SAMHSA's National Registry of Evidence-based Programs and Practices. SPIRIT currently operates in two urban and three rural school districts in different areas of the state. These school districts serve high-risk populations characterized by: 1) high percentage of students qualifying for reduced/free lunches, 2) low standardized test scores, 3) high prevalence of substance use, 4) low graduation rates, and/or 5) high rate of juvenile justice referrals. Screening and referral services are provided. In FY 2012, about 10,400 students participated in the SPIRIT program. DBH contracts with the Missouri Institute of Mental Health to conduct an annual evaluation of the SPIRIT program.

DBH also funds other selective prevention services and early intervention activities for designated children, youth, and families. These services involve structured programming and/or a variety of activities including informational sessions and training. Target groups include youth experiencing academic failure and low-income youth and families. Programs are located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in

southeastern Missouri known as the "Bootheel". DBH contracts with the Missouri Alliance of Boys and Girls Club sites throughout the state for implementation of SMART Moves (Skills Mastery and Resistance Training) serving over 60,000 youth ages 5-18. DBH contracts with the Leadership Through Education and Advocacy for the Deaf (L.E.A.D.) for the provision of prevention services for deaf and hard of hearing youth. L.E.A.D. conducts the annual Teen Institute for the Deaf attended by approximately 40 youth ages 12 to 17.

In 2010, Missouri established an interagency Statewide Epidemiology Outcomes Workgroup (SEOW) through funding support from SAMHSA. The mission of Missouri's SEOW is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;
- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

Missouri's SEOW is chaired by a Research Assistant Professor at the Missouri Institute for Mental Health – University of Missouri, St. Louis. Membership includes data experts from mental health, social services, public safety, health, education, and the judicial system. DBH's Research Coordinator, Director of Quality Improvement, and Director of Prevention and Mental Health Promotion are SEOW members.

Missouri's Youth Suicide Prevention Project (MYSPP) is a statewide youth prevention response to increase awareness and identification of suicide risk factors and warning signs and to facilitate access to behavioral health services for individuals contemplating or attempting suicide. Funded by a three-grant from SAMHSA, MYSPP is implementing gatekeeper training for individuals – particularly, those working with youth - to develop a basic understanding of suicide and gain basic intervention skills. Five Regional Suicide Prevention Resource Centers have been established to provide trainings and services such as educational presentations, depression screenings, resource libraries, and support groups for survivors of suicide. DBH, in collaboration with the Missouri Institute for Mental Health, sponsored the 7th Annual Show-Me You Care about Suicide Prevention Conference attended by 137 educators, human service professionals, military personnel, survivors, and other interested individuals. The University of Missouri – Columbia is also a recipient of a SAMHSA-funded Campus Suicide Grant to train college students, faculty, and staff through *Ask Listen Refer* and *Question Persuade and Refer (QPR)* training programs.

DBH's Crisis Intervention Team (CIT) program is a community-based collaboration that trains law enforcement officers and first responders to take appropriate action with individuals having a mental illness or substance abuse crisis. The program provides specialized training under the instructional supervision of behavioral health providers, family advocates, and behavioral health consumer groups. Training provides an overview of mental illness and substance abuse, discussions with consumers and family members, the development of active listening skills and de-escalation techniques, and information on community resources. CIT training seeks to increase the safety of both the officer and the consumer and to divert the

consumer from jail settings to behavioral health treatment and/or services. Since December 2010, more than 1,300 police officers in Missouri have participated in CIT training.

In 2008, the Missouri Division of Behavioral Health, the Maryland State Department of Health and Mental Hygiene, and the National Council for Community Behavioral Healthcare worked to bring Mental Health First Aid (MHFA), initially developed in Australia, to the United States. MHFA-USA seeks to provide the general public with basic first aid interventions for common behavioral health problems. MHFA is a 12-hour health literacy program that teaches the public how to recognize the signs and symptoms of mental health problems. Over 5,800 individuals have taken the MHFA course in Missouri. A 5-day instructor course is also available for individuals seeking instructor certification. Over 200 individuals have been certified as MHFA instructors in Missouri. In 2009, DBH received a two-year grant in the amount of $300,000 from the Missouri Foundation for Health to provide MHFA programming to church leaders and faith educators in 17 rural counties in southwest and southeast Missouri. A Youth MHFA-USA course has been developed to teach individuals how to help a youth in crisis or experiencing a mental health or substance abuse issue.

Disaster Services

The Department of Mental Health's (DMH) Office of Disaster Services (ODS) conducts planning and development activities to support a coordinated mental health response for Missourians in disaster situations. ODS coordinates efforts with the State Emergency Management Agency (SEMA) and the Department of Health and Senior Services. ODS also develops and administers the FEMA Crisis Counseling Program grant when there is a federal declaration in Missouri. ODS coordinates the DMH Show-Me Response that deploys, in the event of a disaster, volunteers of licensed professionals such as psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, certified substance abuse counselors, and developmental disability professionals. ODS represents DMH on the Governor's Faith-Based & Community Service Partnership for Disaster Recovery to aid Missourians' recovery plans by developing and implementing a holistic approach to disaster recovery.

On May 22, 2011, an EF-5 multiple-vortex tornado hit Joplin, Missouri killing 158 people, injuring over 1,100 people, and causing approximately $2.2 billion in damages. DMH staff and contracted providers worked to coordinate behavioral health services for existing DMH consumers, secure facilities and beds to replace damaged sites and beds taken offline, and to provide immediate crisis services for the community and first responders. The FEMA Crisis Counseling Grant "Healing Joplin" provided counseling services, education, and informational materials through June 2012. In addition, a SAMHA Emergency Relief Grant provided funding for mental health and substance abuse treatment for individuals impacted by the tornado who did not otherwise have resources. In January 2012, a child trauma treatment center *Will's Place* opened to provide ongoing specialized mental health treatment for children and training for adult responders. Will's Place received a SAMHSA grant that will enable the center to be a Category III Community Treatment and Services Center of Excellence and will serve a regional four-state area that includes Missouri, Arkansas, Kansas, and Oklahoma. The Governor's disaster recovery workgroup will monitor the long-term recovery of Joplin.

Administration

The Division of Behavioral Health's (DBH) administration unit includes budgetary/financial analysis and monitoring, grants management, the Customer Information and Management Outcomes and Reporting (CIMOR) Help Desk, and Research and Statistics. In the Research and Statistics unit, DMH's Research Coordinator is also the Drug & Alcohol Services Information System/Treatment Episode Dataset (DASIS/TEDS) manager and the State Synar Coordinator. DBH's Director of Quality Improvement oversees the SAMHSA-funded State Data Infrastructure Grant for the collection, analysis, and reporting of client outcome data for individuals receiving mental health treatment. Process measures and client outcomes data are generated for program monitoring and federal reporting. DBH produces an annual Status Report on Missouri's Substance Abuse and Mental Health Problems that provides epidemiological profiles of the state, its counties, and planning regions. In FY 2012, DBH published its 18th edition of the annual status report and, in collaboration with the state epidemiology workgroup, has implemented a web-based querying tool to facilitate use of behavioral health data at the local level.

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II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Assessment of Need

Behavioral Health Data

The Missouri Department of Mental Health (DMH) planning utilizes prevalence data, behavioral health indicators, treatment admissions data, population estimates, needs assessments, and outcomes data. DMH assimilates behavioral health-related data from several national and state surveys. DMH acquires state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH), state estimates from the Youth Risk Behavior Survey (YRBS), state estimates from the Behavior Risk Factor Survey (BRFS), state and county-level data from the Missouri Student Survey (MSS) for grades 6 through 12, and state data collected from 21 of Missouri's universities and colleges using the Missouri College Health Behavior Survey (MCHBS). DMH annually updates prevalence estimates using the most current survey data.

DMH collects an array of behavioral health indicator data, mostly from other state agencies. The indicators include traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; impaired births; induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements; methamphetamine lab confiscations; probation, parole, and prison admissions; and drug, DUI, and mental health court enrollments. DMH also collects other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment rates. DMH annually assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, service areas, planning regions, and the state.

Substance abuse and mental health treatment admissions data are retrieved from the DMH Customer Information, Management, Outcomes, and Reporting (CIMOR) system, based on each consumer's county of residence. Information on demographics, substances abused, diagnoses, and treatment services are assembled by fiscal year into geographic profiles for the counties, planning regions, service areas, and state. These profiles are included in DMH's annual Status Report on Missouri's Substance Abuse and Mental Health Problems.

State Epidemiology Outcomes Workgroup

In 2010, Missouri was awarded a State Epidemiology Outcomes Workgroup (SEOW) contract, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The state used this funding to revitalize its SEOW workgroup that had been established under Strategic Prevention Framework State Incentive Grant (2004-2009) to address underage drinking. An expanded scope of the new SEOW includes mental health promotion. The mission of Missouri's current SEOW is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;

- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

The SEOW is chaired by a Research Assistance Professor at the Missouri Institute for Mental Health – University of Missouri, St. Louis. DMH's Director of Prevention, Research Coordinator, and Director of Quality Improvement are members of the SEOW. Social services, public safety, health, education, the judicial system, and academia are also represented on the workgroup:

Name	SEW Position	Title	Agency
Susan Depue	chairperson	Research Assistant Professor	Missouri Institute for Mental Health
Angie Stuckenschneider	member	Prevention Director	Missouri Department of Mental Health
Christie Lundy	member	Research Coordinator	Missouri Department of Mental Health
Clive Woodward	member	Director of Quality Improvement	Missouri Department of Mental Health
Rebecca Kniest	member	Research Analyst	Missouri Department of Social Services, Research & Evaluation
Ron Beck	member	Director	Missouri State Highway Patrol, Statistical Analysis Center
Shumei Yun	member	State Epidemiologist	Missouri Department of Health and Senior Services, Division of Community and Public Health
Anne Janku	member	Research Manager	Office of State Courts Administrator
Liz Sale	member	Research Associate Professor	Missouri Institute for Mental Health
Tracy Greever Rice	member	Director	Office of Social and Economic Data Analysis , University of Missouri
Dan Reilly	member	Underage Drinking Prevention Coordinator	Partners in Prevention
Mary Pearce	member	SES Supervisor	Missouri Department Of Elementary And Secondary Education, Office of Data System Management

As part of the SAMHSA-funded Partnership for Success Grant, the SEOW will be responsible for providing data expertise and support to Partnership coalitions in addressing

underage drinking and to the college consortium, Partners in Prevention, in addressing misuse of prescription drugs among college students. As part of the broader behavioral health system, the SEOW workgroup continues to assess data gaps, enhance capacity to use behavioral health data, promote data driven decision-making, increase dissemination of data and analyses, promote common data standards, and increase data collaborations.

Overall Need

Serious Emotional Disturbance (Children) and Serious Mental Illness (Adults)

Substate Planning Area	2011 Population Age 0-17	Estimated Need (7%)	Received Treatment FY 2012	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	183,005	12,810	2,034	10,776	84.12%
Central	491,116	34,378	3,447	30,931	89.97%
Eastern	356,240	24,937	5,550	19,387	77.74%
Southwest	164,378	11,505	2,889	8,616	74.89%
Southeast	217,382	15,217	2,696	12,521	82.28%
State Total	1,412,121	98,847	16,616	82,231	83.19%

Table 1 FY 2012 Estimated prevalence of childhood serious emotional disorder.

Substate Planning Area	2011 Population Age 18+	Estimated Need (5.4%)	Received Treatment FY 2012	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	628,601	33,944	7,410	26,534	78.17%
Central	1,597,805	86,281	15,702	70,579	81.80%
Eastern	1,109,122	59,892	18,512	41,380	69.09%
Southwest	548,856	29,638	11,500	18,138	61.20%
Southeast	714,183	38,565	8,432	30,133	78.14%
State Total	4,598,567	248,320	61,556	186,764	75.21%

Table 2 FY 2012 Estimated prevalence of adult serious mental illness.

State estimates for serious mental illness (SMI) (adults) and serious emotional disturbances (SED) (children) are obtained from estimates published in the federal register (FR Doc. 98-19071; FR Doc. 99-15377). Based on these historically reported estimates required for use in the Block Grant State Plan, approximately 5.4 percent of the Missouri adult population has

an SMI and 7 percent of Missouri children have an SED. It is noted that a more recent estimate from the 2010-2011 National Household Survey on Drug Use and Health (NSDUH) has the prevalence of SMI among Missouri adults at 5.76 percent (SAMHSA, 2012a). Based on national NSDUH data, the estimated number of adults with SMI in the past year who did not receive mental health treatment in the past year is about 41 percent or an estimated 101,812 Missouri adults with SMI (SAMHSA, 2012d). For the remaining 146,510 Missouri adults with SMI who did received some level of mental health treatment, it is not known what portion of these received a sufficient level of care to address their SMI condition. A study by Mark and Buck (2006) examining characteristics of U.S. youth with SED found that about 44 percent were covered by private insurance, 31 percent were enrolled in Medicaid/Children's Health Insurance Program (CHIP), 11 percent were covered by another unspecified public program, and about 14 were uninsured. It is reasonable to assume that the majority if not the entire uninsured group represents unmet need. It is not, however, known what portion of the private insurance group did not have sufficient coverage for adequate care of the child's SED condition.

As of August 2013, it is not known if Missouri will expand its Medicaid program to 138 percent of the federal poverty level. The majority of Department of Mental Health consumers with SMI do not have private insurance.

Substance Abuse

Substate Planning Area	2011 Population Age 12-17	Estimated Need	FY 2012 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	117,576	7,670	724	6,946	90.56%
Central	61,080	4,255	500	3,755	88.25%
Eastern	171,372	12,251	807	11,444	93.41%
Southwest	73,517	5,328	512	4,816	90.39%
Southeast	56,050	3,493	552	2,941	84.20%
State Total	479,595	32,997	3,095	29,902	90.62%

Table 3 FY 2012 Estimated prevalence of adolescent substance abuse disorder.

Substate Planning Area	2011 Population Age 18+	Estimated Need	FY 2012 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	1,109,122	85,588	9,502	76,086	88.90%
Central	628,601	48,795	5,707	43,088	88.30%
Eastern	1,597,805	131,801	11,068	120,733	91.60%
Southwest	714,183	54,324	6,975	47,349	87.16%
Southeast	548,856	40,490	7,450	33,040	81.60%
State Total	4,598,567	360,998	40,702	320,296	88.73%

Table 4 FY 2012 Estimated prevalence of adult substance abuse disorder.

County-level population of persons age 12 or older was obtained from the Missouri Census Data Center and aggregated to the substate areas (Missouri Census Data Center, 2012). Statewide estimates for substance abuse treatment need are obtained from the National Household Survey (NSDUH) (2009-2010) (SAMHSA, 2012b). The total is allocated among the substate planning areas in accordance with substate estimates obtained from the 2008-2010 NSDUH (SAMHSA, 2012c). The difference between estimated need and number served yields the combination of estimated served outside of the state system and unmet need. As of August 2013, it is not known if Missouri will expand its Medicaid program to 138 percent of the federal poverty level. Less than four percent of DMH consumers receiving substance abuse treatment in FY 2012 had private health insurance at the time of admission.

Coordination of Primary Care and Behavioral

Individuals with serious mental illness die 11 to 32 years prematurely from preventable chronic health conditions such as heart disease, diabetes, cancer, pulmonary disease, and stroke (National Institute on Mental Health, 2012). In addition, individuals with co-occurring mental illness and substance abuse disorders are at greater risk for relapse and tend to have poorer outcomes in comparison to individuals with only a substance abuse disorder (Compton, W.M., Cottler, L.B., Behn-Abdallah, A., & Spitnagel, E.L., 2003; Hser, Y.I., Evans, E., Teruva, C., Huang, D., & Anglin, M.D., 2007). Expenditures for co-occurring individuals on Medicaid tend to be higher because of not only the substance abuse and mental illness disorders but also accompanying physical disorders (Clark, R.E., Samnaliev, M., & McGovern, M.P., 2009). The Missouri Department of Mental Health (DMH) has recently implemented a Health Home model for its Community Mental Health Centers (CMHC). Under this model, individuals with serious mental illness served by the CMHC's have monitoring of their health status; coordination of their care including their physical health needs; individualized care planning; and promotion of self-management. For an individual to be eligible for enrollment in Missouri's Health Home, he/she must meet one of the following three conditions:

1) have a serious and persistent mental illness,
2) have a mental health condition and a substance abuse disorder, or
3) have a mental health condition or a substance abuse disorder and one other chronic health condition.

Strategic Prevention Partnership

	Missouri	U.S.
Past Month Alcohol Use, Age 12 to 17	15.16%	14.23%
Past Year Nonmedical Pain Reliever Use, Age 18 to 25	13.22%	11.54%

Table 5 Estimated percentages for adolescent alcohol use and misuse of prescription drugs by young adults (SAMHSA, 2012b).

Substance use and misuse has a significant impact on Missouri communities and young people. Based on data from the National Household Survey on Drug Use and Health (NSDUH),

394,000 Missourians age 12 and older struggle with a substance abuse problem. Of these, 152,000 are under the age of 26 (SAMHSA, 2012b). For individuals age 12 or older entering substance abuse treatment in Missouri, the average age reported for first using the primary substance of abuse is 17.4 years of age. By type of substance abused, it is lower for marijuana (14.3 years) and alcohol (15.5 years) and higher for drugs such as methamphetamine (20.3 years) and heroin (21.5 years). For individuals entering treatment for a prescription drug problem, the average age of first misuse is 22.7 years of age (Missouri Department of Mental Health, 2012). Thus, the early teenage years through young adulthood present a critical time period for education, further development of health skills, and other supports promoting a substance-free lifestyle.

In Missouri, an estimated 15.16 percent of adolescents age 12 to 17 currently use alcohol (Table 5). This is higher than that for the U.S. adolescents (14.23%). An estimated 13.22 percent of young adults misuse pain relievers in the past year – higher than that for the U.S. young adults (11.54%). Misuse of prescription drugs tends to be more prevalent in rural counties as opposed to urban counties in Missouri (SAMSHA, 2012c). In October 2012, Missouri was awarded a Strategic Prevention Framework – Partnerships for Success II Grant to use data-driven strategic planning in communities of high need to address underage drinking and prescription drug misuse.

Chronic Drunk Driving

Substate Planning Area	DWI Offenders with 4+ DWI's with the Most Recent DWI Occurring in the Past 3 Years	FY 2012 Number Served in Serious and Repeat Offender Program	Unmet Need	Penetration Gap
Northwest	1,376	269	1,107	80.45%
Central	712	121	591	83.01%
Eastern	1,356	588	768	56.64%
Southwest	962	290	672	69.85%
Southeast	825	116	709	85.94%
Total	5,231	1,384	3,847	73.54%

Table 6 Estimated need for intensive treatment for chronic drunk drivers.

In Missouri, the Department of Revenue (DOR) is responsible for collecting DWI arrest data from enforcement agencies and is authorized to take administrative action if an individual's blood alcohol content is over the legal limit or if the driver refuses to submit to an alcohol and/or drug test when requested by a law enforcement officer. The Missouri Department of Mental Health (DMH) obtains the drivers' license abstract file from DOR on a quarterly basis. Resident addresses are geocoded and the corresponding substate planning area is determined using geographic information system (GIS) analysis. The number of non-deceased individuals who had four or more DWI's with the most recent DWI occurring in the past three years is

determined. The number of individuals who received treatment in the Serious and Repeat Offender Program (SROP) is obtained from the DMH billing system. Estimated unmet need is the difference between number of chronic offenders and the number served in the SROP program. Penetration gap is that proportion of chronic offenders with recent DWI who did not received long-term treatment.

Department of Corrections Community Supervised Offenders

Substance Abuse

Substate Planning Area	FY 2012 Probation and Parole Population	Probation and Parole Need	Probation and Parole FY 2012 Served	Estimated Unmet Need	Penetration Gap
Northwest	22,221	15,904	4,426	11,478	72.17%
Central	14,240	10,039	3,176	6,863	68.36%
Eastern	35,214	24,783	4,704	20,079	81.02%
Southwest	13,246	9,236	2,634	6,602	71.48%
Southeast	18,573	13,109	5,073	8,036	61.30%
State Total	103,494	73,071	20,013	53,058	72.61%

Table 7 Estimated need for substance abuse treatment among parole and probation offenders.

The number of individuals on parole or probation for FY 2012 was obtained from the Missouri Department of Corrections (DOC). Estimated need for substance abuse treatment was determined from the DOC Substance Abuse Classification Assessment (SACA). Most individuals receive an assessment when they enter prison and when they start community supervision. An estimated 83 percent of parolees and 66 percent of probationers need substance abuse treatment (Missouri Department of Corrections, 2012). Number served in the publicly-funded system for FY 2012 was obtained from the Missouri Department of Mental Health billing system. Estimated unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment.

Mental Illness

Substate Planning Area	FY 2012 Probation and Parole Population	Probation (14%) and Parole (11.9%) Need	Probation and Parole FY 2012 Served	Estimated Unmet Need	Penetration Gap
Northwest	22,221	3,555	1,835	1,720	48.39%
Central	14,240	2,278	832	1,446	63.48%
Eastern	35,214	5,634	1,786	3,848	68.30%
Southwest	13,246	2,119	535	1,584	74.76%
Southeast	18,573	2,972	1,525	1,447	48.68%

Substate Planning Area	FY 2012 Probation and Parole Population	Probation (14%) and Parole (11.9%) Need	Probation and Parole FY 2012 Served	Estimated Unmet Need	Penetration Gap
State Total	103,494	16,559	6,513	10,046	60.67%

Table 8 Estimated need for serious mental illness treatment among parole and probation offenders.

The number of individuals on parole or probation for FY 2012 was obtained from the Missouri Department of Corrections (DOC). Estimated need for mental illness treatment was determined from the 2011 National Household Survey on Drug Use and Health. An estimated 11.9 percent of individuals on parole and 14 percent of individuals on probation have a serious mental illness in the past year (SAMHSA, 2012d). Number served in the publicly-funded system for FY 2012 was obtained from the Missouri Department of Mental Health billing system. Estimated unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment.

Tobacco Prevention / Cessation

Past Month Cigarette Use for Selected Groups	Missouri	U.S.
Individuals with Serious Mental Illness in Past Year	44.7%	45.3%
Individuals without a Serious Mental Illness in Past Year	27.2%	23.6%
Individuals with an Alcohol or Drug Abuse/Dependence Problem in Past Year	62.2%	55.3%
Individuals without an Alcohol or Drug Abuse/Dependence Problem in Past Year	26.4%	21.2%
Youth Age 12-17	14.4%	10.2%
Young Adults Age 18-25	43.1%	37.3%

Table 9 Prevalence of Current Cigarette Use (SAMHSA, 2012e)

Estimates of past month cigarette use were obtained from the two-year combined 2010-2011 National Household Survey on Drug Use and Health (SAMHSA, 2012e). Prevalence of cigarette use for Missouri tends to be higher than that for the U.S. Cigarette use for individuals with a serious mental illness or an alcohol or drug problem tend to be much higher than those without a serious mental illness or an alcohol or drug problem.

Research has shown that higher merchant compliance with tobacco control laws predicts lower levels of youth smoking (DiFranza, Savageau, & Fletcher, 2009). The Missouri Department of Mental Health - Division of Behavioral Health (DBH) is the state agency that oversees the state's federal Synar requirements and partners with the Department of Public Safety – Division of Alcohol and Tobacco Control for tobacco control efforts. Federal Synar regulations require all states to maintain a retailer non-compliance rate of no more than 20

percent (42 U.S.C. 300x-26 and 45 C.F.R. 96.130). Since 1996, DBH is charged with overseeing the Synar requirements in Missouri, conducting the annual Synar survey, and implementing tobacco prevention activities as it relates to the sale of tobacco products to minors. A state that fails to comply with the federal Synar requirements is at risk for losing Substance Abuse Prevention and Treatment Block Grant funding.

Recovery Support Services

Substance Abuse

Substate Planning Area	Estimated Number with a Substance Abuse Disorder in Past Year	Number that Received Recovery Support Services in the State System in FY 2012
Northwest	93,258	2,859
Central	53,050	412
Eastern	144,052	28
Southwest	59,652	1,303
Southeast	43,983	354
State Total	393,995	4,956

Table 10 Estimated Substance Abuse Prevalence and Number Served with Recovery Support Services

Research has shown that, for many individuals, recovery coaching, 12-step programs, spirituality, and social and community supports play an important role in maintaining long-term recovery from substance addiction (SAMHSA, 2009). While the Missouri Department of Mental Health (DMH) has sought additional state funding to support recovery support services in the past, serious state budget deficits and difficult economic conditions have precluded such funding. DMH has received three SAMHSA-funded Access to Recovery (ATR) Grants: ATR I which ended in 2007, ATR II which ended in 2010, and ATR III which is scheduled to end in 2014. Under ATR I, DMH implemented a voucher system and created a network of recovery support providers including many faith-based providers. Under ATR II, the state increased focus on the implementation of evidence-based practices and added reentry coordination services to the menu of recovery support services. Under ATR III grant, DMH has implemented a model to focus on local recovery-oriented systems of care and to provide outreach and priority to 1) Veterans and National Guard soldiers, 2) Treatment court participants, and 3) Department of Corrections offenders returning to the community. Due to funding limitations, recovery support services funded through ATR III are only available to 21 of the state's 114 counties. It is not known how many individuals receive recovery support services from outside the state system.

Serious Mental Illness

For the provision of behavioral healthcare to individuals with severe mental illness, research has shown that peer support staff function at least as well as non-peer staff in roles such as case managers, rehabilitation staff, and outreach workers. Moreover, peer services tend to

generate better outcomes in engaging the "difficult-to-engage" clients, reducing hospitalizations for clients, and in decreasing substance use among co-occurring clients (Davidson, L., Bellamy, C., Guy, K., & Miller, R., 2012). Findings from the SAMHSA Consumer-Operated Service Program Multisite Research Initiative showed that adding peer support services or programs to traditional mental health programs was positively associated with increased personal empowerment among clients using those services (Rogers et al., 2007). DMH funds five drop-in centers: two in St. Louis, two in Kansas City, and one in Springfield. DMH's five Warm (non-crisis) Lines offer safe, confidential telephone support by peers when an individual with a mental illness or family member needs information, referral, or to talk to someone. In calendar year 2012, there were 40,528 visits to the drop-in centers and 11,741 calls to the peer phone lines. An estimated 248,320 adults in Missouri have a serious mental illness and an estimated 98,847 children have a serious emotional disturbance. It is likely that most of these individuals would benefit from and/or seek recovery support services if available.

After researching peer support training curricula, the Comprehensive Psychiatric Services State Advisory Council (CPS/SAC) made the recommendation for the Appalachian Consulting Group "Georgia Model" which was subsequently adopted by the Division of Behavioral Health. The Department of Mental Health (DMH) is moving the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. One primary strategy in transforming the system is to recognize the power of consumer as providers. Recognizing consumers as providers is taking root in the mental health system. Emerging evidence supports the need for peer support services as a cost-effective and complementary adjunct to professional mental health services and supports. Peer support services can move the system to focus less on illness and disability and more on wellness. To accomplish this goal, Missouri has provided equal weight to expertise gained through the "lived experience" as is done with any other credential or knowledge base. A Peer Specialist can share lived experiences of recovery, share and support the use of recovery tools, and model successful recovery behaviors. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. Additionally, Peer Specialists can help consumers connect with other consumers and with their community at large.

With the oversight of the CPS/SAC, Peer Specialist Basic Trainings have been conducted since 2008. The week-long training has been conducted by trained individuals with lived experience of recovery. To date 270 individuals have been trained and 170 have reached the goal of Certified Missouri Peer Specialist (CMPS) status. Twenty community mental health centers have sent individuals to the training and 12 have certified peer specialists working in their agencies. Ten Consumer Operated Services Program Drop-In Centers and Warm Lines sent individuals to the training. Additionally, the Veteran's Administration, residential providers, Services for Independent Living, and substance abuse treatment agencies have sent individuals to

the training. Five of the state operated inpatient facilities have active CMPS on staff. The Medicaid reimbursement rate has been increased to be comparable to that of the Community Support Worker in an effort to incentivize the hiring of Certified Peer Specialists in the CMHC's.

In 2011, Wellness Coaching Training was provided to 20 selected CMPS by Dr. Peggy Swarbrick, Assistant Professor at the University of Medicine and Dentistry of New Jersey-Department of Psychiatric Rehabilitation and Counseling Professions. The training was highly successful and the Division of Behavioral Health has subsequently expanded the training to all Peer Specialists and Community Support Workers. In FY 2014 and FY 2015, additional basic trainings and continuing education trainings are scheduled. DMH has contracted with Wichita State University to provide the web site support for the training and certification process. The web site is www.peerspecialist.org.

Medication Assisted Treatment for Addiction

Substate Planning Area	FY 2012 Number Served who Had an Alcohol and/or Opiate Problem	FY 2012 Number who Received MAT Services	% Received MAT Services
Northwest	7,190	780	10.85%
Central	4,618	313	6.78%
Eastern	9,594	1,904	19.85%
Southwest	5,120	184	3.59%
Southeast	5,433	383	7.05%
State Total	31,955	3,564	11.15%

Table 11 Number served in state system with an Opioid or alcohol problem identified as the primary, secondary, or tertiary substance abuse problem and the number who received MAT services including methadone, Vivitrol, naltrexone, buprenorphine/Suboxone, Antabuse, and acamprosate.

Medication assisted treatment (MAT) is the use of medications, in combination with psychosocial counseling, to support treatment and recovery from substance abuse disorders. DMH fully supports the use of evidence-based practices in substance abuse treatment, which includes MAT. DMH funds four Opioid treatment programs (3 contracted and 1 state-operated) that are certified to provide methadone maintenance treatment. Two agencies are located in St. Louis, and two are located in Kansas City. In addition, DMH has been introducing new medications into its non-Opioid treatment programs since 2006 as part of a Robert Woods Johnson Advancing Recovery Grant. Medication services were added to treatment contracts in 2007. In 2010, Missouri began credentialing for a MAT specialty. DMH continues to work to integrate MAT into addition treatment where clinically appropriate. The National Quality Forum recommendations state that pharmacotherapy should be made available to all adult patients

diagnosed with an alcohol or Opioid dependence if no medical contradictions are applicable (National Quality Forum, 2007).

DMH is working with the Department of Corrections to implement a pilot project involving medication assisted treatment at Ozark Correctional Center in Fordland. Approximately 50 individuals who are returning to the St. Louis area and volunteer to participate will receive one injection of Vivitrol 3 to 4 days prior to their release. Vivitrol blocks opiate receptors in the brain thereby eliminating the euphoric effects and preventing cravings for alcohol and opiate drugs such as heroin. It is administered in the form of a shot once per month. These individuals will receive follow-up medication and substance abuse counseling through DMH contracted community agencies in St. Louis. It is anticipated that these individuals will be less likely to relapse to alcohol or opiate use upon their release from prison, thereby reducing the likelihood of re-arrest and re-incarceration. The University of Missouri-St. Louis, Missouri Institute of Mental Health will be conducting the project evaluation.

Community Advocacy and Education

Substance Abuse

Approximately 395,000 Missourians have a substance abuse problem (SAMHSA, 2011a). Alcohol, tobacco, and other drug (ATOD) use are impacted by social acceptability including community laws and norms favorable toward use as well as by availability of the substances. Missouri's 164 community coalitions; the 11 regional support centers; and Missouri's higher education substance abuse consortium, Partnerships in Prevention (PIP) work to change community norms, policy, and substance availability in support of creating healthy, safe communities. The Regional Support Centers, in collaboration with the community coalitions, develop, implement, and evaluate a comprehensive strategic plan with identified target outcomes based on community needs.

	Missouri	U.S.
Nonmedical Use of Pain Relievers in Past Year, Age 12+	4.83%	4.57%
Alcohol Use in Past Month, Age 12-17	14.96%	13.47%
Tobacco Use in Past Month, Age 12+	33.75%	26.97%

Table 12 Estimates of Substance Use/Abuse (SAMHSA, 2012a)

Substate Planning Area	Heroin Treatment Admissions per 10,000 Population
Northwest	0.81
Central	2.08
Eastern	11.94
Southwest	0.92

Substate Planning Area	Heroin Treatment Admissions per 10,000 Population
Southeast	3.22
State Total	5.15

Table 13 Rates of heroin-related admissions to substance abuse treatment in FY 2012 (Missouri Department of Mental Health, 2012b).

Some issues facing Missouri's communities include: 1) methamphetamine laboratories in rural parts of the state, particularly in Southeast and Southwest Missouri; 2) a problem with prescription drug misuse; 3) underage drinking, and 4) increased availability and use of heroin in Eastern Missouri. In addition, the statewide use of tobacco products tends to be higher than that for the country as a whole. From January through November 2012, Missouri had 1,856 methamphetamine incident seizures – higher than any other state (Missouri Department of Public Safety, 2012). Approximately 4.83% of Missourians age 12 or older engage in nonmedical use of pain relievers in the past year (SAMHSA, 2011a). In FY 2012, Eastern Missouri had a higher rate of heroin-related admissions to substance abuse treatment compared to that of other regions of the state (Missouri Department of Mental Health, 2012). Current use of tobacco by Missourians age 12 or older is 33.75 percent – higher than that for the United States (26.97%) (SAMHSA, 2012a).

Mental Illness

	Age 12-17		Age 18+	
	Missouri	U.S.	Missouri	U.S.
Serious Mental Illness in the Past Year			5.76%	4.99%
Had Serious Thoughts of Suicide in Past Year			4.13%	3.75%
Had at Least One Major Depressive Episode in the Past Year	8.61%	8.15%	7.27%	6.70%

Table 14 Prevalence of Mental Illness (SAMHSA, 2012a).

Behavioral health issues such as substance addiction and mental illness often carry a stigma that prevents individuals from seeking help and others from providing help. Of those Missourians who experience serious psychological distress in the past year, an estimated 50 percent do not receive any mental health treatment (SAMHSA, 2012f). Research has shown that Mental Health First Aid, a public education program designed for the general public in appropriately responding to behavioral health issues, is associated with increased knowledge of behavioral health disorders, less stigmatization, and greater confidence to provide assistance (Kitchener, J.A., 2004; Kitchener, B.A. & Jorm, A.F., 2004). The Missouri Department of Mental Health has partnered with the Maryland Department of Health and Mental Hygiene and

the National Council for Community Behavioral Healthcare to implement Mental Health First Aid USA, modeled after a program developed in Australia. Missouri is piloting a second version of Mental Health First Aid for adults who work with young people – Mental Health First Aid for Youth.

Evidence-based Behavioral Health Practices

The Department of Mental Health (DMH) supports implementation of programs and practices that have proven effectiveness in reducing the impact of behavioral health disorders on individuals and families in Missouri. Missouri has implemented the following evidence-based practices in the treatment of serious mental illness (SMI):

- Integrated treatment for co-occurring mental illness and substance use disorders,
- Supported employment,
- Illness management and recovery,
- Assertive community treatment, and
- Consumer-operated services.

Individuals with co-occurring SMI and substance abuse disorders tend to have poorer outcomes when served in traditional treatment programs where each disorder is treated by a separate team of providers (McGovern, M.P., 2006). The evidence-based treatment model of care for persons with co-occurring disorders that is recommended by SAMHSA is the Integrated Treatment for Co-Occurring Disorders (ITCOD). In the ITDOC model persons receive coordinated, integrated treatment by a single multidisciplinary team including trained specialists in co-occurring disorders. Missouri has 20 ITCOD programs operating in 32 locations. Missouri has Medicaid approved billing codes for co-occurring individual counseling, group education, group counseling, and a supplemental individual assessment for substance abuse disorders. DMH monitors fidelity to the SAMHSA tool kit.

Supported employment programs have been shown to be more effective than traditional vocational programs in gaining competitive employment, earning more income, and working more days for individuals with SMI (Bond, G.R. *et al*., 2008; Crowther, R.E. *et al*., 2001). Missouri has seven supported employment programs. The State's programs have received technical assistance and fidelity training from the Dartmouth Psychiatric Research Center through a grant from Johnson & Johnson. Providers collaborate with the Division of Vocational Rehabilitation (VR) venders to offer supported employment services to ensure that:

- Eligibility is based on consumer choice;
- Supported employment is integrated with treatment;
- Competitive employment is the goal;
- Job search starts soon after the consumer expresses interest in working;
- Follow-along supports are continuous; and
- Consumer preferences are recognized.

Fidelity is monitored for the Individualized Placement and Support Supported Employment model.

Illness management recovery strategies have been shown to increase the individual's knowledge of their condition, aid in medication compliance, and reduce the occurrence and severity of symptom relapse (Mueser, K.T. *et al*., 2002). DMH, in collaboration with the State Medicaid authority, has established an enhanced rate for Psychosocial Rehabilitation. Twenty community mental health centers provide these services that focus on health, wellness, and recovery. Fidelity to this evidence-based practice is not monitored.

Assertive Community Treatment (ACT) has been shown to reduce hospitalizations for individuals with severe mental illness (Phillips, S.D. *et al*., 2001). In Missouri, ACT services are made available to adults with serious and persistent mental illness who: 1) are high users of inpatient beds, 2) may have a co-occurring substance abuse disorder, 3) have involvement with the criminal justice system, and 4) are homeless. DMH funds seven ACT programs. Missouri has obtained technical assistance from the ACT Center of Indiana and continues to monitor fidelity of its implementation.

Research has shown that peer support staff function at least as well as non-peer staff in roles such as case managers, rehabilitation staff, and outreach workers. Moreover, peer services tend to generate better outcomes in engaging the "difficult-to-engage" clients, reducing hospitalizations for clients, and in decreasing substance use among co-occurring clients (Davidson, L., Bellamy, C., Guy, K., & Miller, R., 2012). Findings from the SAMHSA Consumer-Operated Service Program (COSP) Multisite Research Initiative showed that adding peer support services or programs to traditional mental health programs was positively associated with increased personal empowerment among clients using those services (Rogers et al., 2007). DMH funds 10 COSP programs. Fidelity to the COSP is monitored using the SAMHSA tool kit.

In addition to the evidence based practices listed above, DMH also funds Dialectical Behavior Therapy (DBT), a cognitive-behavioral treatment initially developed to treat individuals with borderline personality disorder (BPD) but has also been found to be effective for persons with other diagnoses. Several studies have shown that DBT had better outcomes in the treatment of BPD compared to treatment as usual on measures of anger, parasuicidality, and mental health (Stoffers, J.M. *et al*., 2012). Introductory and advanced DBT training has been made available statewide. DMH has partnered with the University of Missouri Psychiatric Center to produce an online training in communication strategies. DMH also supports a DBT website (www.dbtmo.org) to provide information on DBT and the DBT certification process.

Substance Abuse-Related Services for IV Drug Users

Substate Planning Area	2012 Population Age 15+	Estimated IVDU Need	IVDU FY 2012 Served	Estimated IVDU Need but Not Receive	Penetration Gap
Northwest	1,167,899	5,605	1,240	4,365	77.88%
Central	659,520	3,165	966	2,199	69.48%
Eastern	1,685,231	10,448	2,982	7,466	71.46%
Southwest	750,925	3,604	1,807	1,797	49.86%
Southeast	577,290	2,770	1,421	1,349	48.70%
State Total	4,840,865	25,592	8,416	17,176	67.11%

Table 15 Estimates of prevalence and need for the treatment of IV drug use.

In the past, the number of intravenous drug users (IVDU) was estimated at 0.19 percent of the population aged 12 or older from NSDUH national-level data. Based on 1) the number of IV drug users served and the number on wait lists and given that 2) NSDUH excludes some populations with higher rates of drug use such as incarcerated individuals, homeless, hospitalized patients, and college dormitory students, the NSDUH estimate was believed to generate estimates for Missouri that seriously underestimates the number of IV drug users in the state. Research from Brady *et al*. estimated the prevalence of IV drug users in the U.S. and in 76 metropolitan statistical areas (MSA) (Brady, J.E. *et al*., 2008). Brady's estimates for IV drug users in the Kansas City and St. Louis MSA's exceeded that generated from the NSDUH data by a factor of 2.7 and 3.4, respectively. Brady's prevalence rate for Kansas City MSA and St. Louis MSA was applied to the populations of Northwest and Eastern regions. The remaining regions were assumed to have a similar rate as that of Northwest region and a corresponding estimate was generated for the remaining regions. The number of IVDU's served by substate region was obtained from the publicly-funded system (Missouri Department of Mental Health, 2012a). The estimated number for unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment. In Missouri, methamphetamine IV drug use is prevalent throughout the rural areas of the state but is particularly notable in Southwest, Southeast, and Northwest Regions. Heroin and other Opioid IV drug use are highly concentrated in Eastern Region impacting both urban and rural locations. Ninety percent of the state's heroin-related deaths are reported from Eastern Region (Missouri Department of Health and Senior Services, 2012).

Substance Abuse-Related Services for Pregnant Women and Women with Dependent Children

	Missouri	U.S.
Pregnant Females	4.8%	8.0%
Females with Children (Age <18) in the Household	7.7%	6.4%

	Missouri	U.S.
Females without Children (Age <18) in the Household	6.7%	6.1%
All Females, Age 12+	7.2%	6.2%

Table 16 Prevalence of substance abuse problems among women (SAMHSA, 2012g).

An estimated 7.7 percent of females with children under the age of 18 in the household and 4.8 percent of pregnant females in Missouri have an illicit drug or alcohol problem (SAMSHA, 2012f). The prevalence of substance abuse problems is lower for Missouri's pregnant females (4.8%) in comparison to that for the United States (8.0%) but is higher for females with children in the household (7.7% vs. 6.4%).

Substate Planning Area	2012 Female Population Age 12+	Women Need (7.2%)	Women FY 2012 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	641,432	46,183	3,408	42,775	92.62%
Central	336,032	24,194	1,965	22,229	91.88%
Eastern	928,763	66,870	4,219	62,651	93.69%
Southwest	394,528	28,406	2,498	25,908	91.21%
Southeast	296,933	21,379	2,575	18,804	87.96%
State Total	2,597,688	187,032	14,665	172,367	92.16%

Table 17 Prevalence of substance abuse problems among women (SAMHSA, 2012g).

County-level population of females age 12 or older was obtained from the Missouri Census Data Center and aggregated to the substate areas (Missouri Census Data Center, 2012). The estimated percent in need of treatment (7.2%) is obtained from the 8-year National Household Survey on Drug Use and Health (NSDUH) dataset (2002-2009) for females in Missouri. The number served in the state system in FY 2012 was obtained from the Department of Mental Health information system. The difference between estimated need and number served is a combination of number served outside of the state system and unmet need. As of August 2013, it is not known if Missouri will expand its Medicaid program to 138 percent of the federal poverty level. Less than four percent of female consumers receiving substance abuse treatment in FY 2012 had private health insurance at the time of admission.

Tuberculosis-Related Services for Individuals Accessing Substance Abuse Treatment

Substate Planning Area	TB Rate per 100,000 Persons
Central	0.74

Substate Planning Area	TB Rate per 100,000 Persons
Eastern	1.78
Northwest	1.65
Southeast	1.96
Southwest	0.86
State Total	1.49

Table 18 Incidence of TB disease in 2012 for the Missouri population.

The number of new cases of tuberculosis (TB) for the Missouri population are obtained from the Missouri Department of Health and Senior Services by county and aggregated to the planning region. The TB incidence rates for Missouri were 1.6 and 1.49 cases per 100,000 persons for 2011 and 2012, respectively. In comparison, the TB incidence rate for the United States in 2011 was 3.4 cases per 100,000 persons (Centers for Disease Control and Prevention, 2012). Risk factors associated with TB transmission include illicit drug use, excessive alcohol consumption, homelessness, previous incarceration, and HIV/AIDS (Nava-Aquilera, E. *et al*., 2009). An important component of TB control is the screening and the testing or referral for TB testing, as appropriate, for individuals admitted to and continuing in substance abuse treatment.

Employment

Substance Abuse

Substate Planning Area	FY 2012 Adults Discharged with a Known Employment Status	Number Employed at Discharge	Percent Employed at Discharge
Northwest	7,137	2380	33.3%
Central	4,340	1704	39.3%
Eastern	8,024	2564	32.0%
Southwest	5,202	1843	35.4%
Southeast	5,726	1857	32.4%
State Total	30,429	10,348	34.0%

Table 19 Employment status for consumers discharged from substance abuse treatment in FY 2012.

Serious Mental Illness

Substate Planning Area	CY 2012 Adults in Community Mental Health Treatment with a Known Employment Status at Annual Review or Discharge	Number Employed at Annual Assessment or Discharge	Percent Employed at Annual Assessment or Discharge
Northwest	4,236	555	13.1%
Central	3,127	396	12.7%
Eastern	5,762	699	12.1%
Southwest	2,452	203	8.3%
Southeast	2,859	252	8.8%
State Total	18,436	2,105	11.4%

Table 20 Employment status for consumers in or discharged from community mental health treatment in calendar year 2012.

Traditional behavioral health treatment has focused on the behavioral health issues believing that once recovery is achieved that employment will naturally follow. Meaningful occupation has a powerful therapeutic impact for individuals recovering from substance abuse and/or mental illness. Identified barriers to employment for individuals with behavioral health issues often include low educational attainment, lack of developed job skills, low motivation, learned helplessness, and poor social supports (Jason, L.A. *et al*., 2001). SAMHSA's Treatment Improvement Protocol (TIP) Series 38 recommends that vocational services be an integral component of substance abuse treatment (SAMHSA, 2000). Research has also shown that adding a vocational focus to mental health rehabilitation can help individuals with serious mental illness (SMI) develop skills and positive attitudes (Blankertz, L. & Robinson, S., 1996). Characteristics associated with obtaining and maintaining employment among people with SMI include having: 1) confidence and motivation to work, 2) work-related skills, 3) work-related opportunities, 4) ongoing access to mental health services in addition to 5) receiving social support (Dunn, E.C. *et al*., 2010). Supported employment programs have been shown to be more effective than traditional vocational programs in gaining competitive employment, earning more income, and working more days for individuals with SMI (Bond, G.R. *et al*., 2008; Crowther, R.E. *et al*., 2001). In 2012, the employment rates for individuals in substance abuse treatment (34%) and in treatment for SMI (11.4%) were considerably lower than that of the general population (59.6%) (Missouri Department of Mental Health, 2012a; U.S. Bureau of Labor Statistics, 2013).

Transition-Age Youth and Young Adults who Have SMI

Substate Planning Area	2011 Population 16-17	2011 Population 18-25	Estimated Need, Age 16-17 (7%)	Estimated Need, Age 18-25 (5%)	Total Estimated Need
Northwest	39,552	158,698	2,768	7,934	10,702

Substate Planning Area	2011 Population 16-17	2011 Population 18-25	Estimated Need, Age 16-17 (7%)	Estimated Need, Age 18-25 (5%)	Total Estimated Need
Central	20,743	115,321	1,452	5,766	7,218
Eastern	59,188	218,389	4,143	10,919	15,062
Southwest	24,599	105,351	1,721	5,267	6,988
Southeast	19,146	75,305	1,340	3,765	5,105
State Total	163,228	673,064	11,424	33,651	45,075

Table 21 Estimated need for mental health services among transition age youth and young adults.

Individuals who are transitioning into adulthood and have or develop a serious mental illness face unique challenges. Compared to the general population, these individuals tend to have increased difficulty in reaching developmental milestones such as graduating from high school, gaining employment, securing stable housing, and developing and sustaining meaningful relationships. In a study by the U.S. Government Accounting Office (GAO) (2008), young adults age 18 to 26 with SMI graduated from high school at a lower rate compared to those without SMI (64% vs. 83%). For young adults who were receiving disability payments from SSI or DI, the high school graduation rate was even lower at 52%. Transition-age youth are more likely to become involved with the juvenile justice system and are at increased risk for substance abuse (Gilmer, T. P. *et al*., 2012). Although SMI may develop earlier than age 16, it is not uncommon for the diagnosis to be made during the late teens and early twenties. As such, individuals and their families may be inexperienced at navigating multiple systems of care and programs. Adult and youth programs often have differing eligibility requirements and service mix that can cause disruptions in continuity of care once an individual reaches age 18. In looking at mental health service utilization in the U.S., Pottick & *et al*. (2008) found that service utilization fell by almost 50 percent at the age of emancipation. Adult programs may be more tailored to the needs of older adults which may cause young adults to feel disenfranchised and result in treatment drop-out (GAO, 2008). In FY 2012, DMH provided community-based mental health services to 11,723 transition-aged youth and young adults (Missouri Department of Mental Health, 2012a).

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II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

#	Priority Area	Priority Type	Population	Action
2	Coordination of Primary Care and Behavioral Health Services	MHS	SMI, SED	View

#	Performance Indicator	
1	Obtain CMS approval of state plan amendment for incentive payments	View
2	Number of CMHC's with CARF accreditation for Behavioral Health Homes	View
3	Number of individuals participating in Health Homes per year	View

#	Priority Area	Priority Type	Population	Action
3	Strategic Prevention Partnerships	SAP	Other	View

#	Performance Indicator	
1	Number of youth served per year	View
2	Number of training and technical assistance activities funded per year	View

#	Priority Area	Priority Type	Population	Action
4	Chronic Drunk Driving	SAT	Other	View

#	Performance Indicator	
1	Number served in the Serious and Repeat Offender Program per year	View

5	Department of Corrections Community Supervised Offenders	SAT, MHS	SMI, Other	View

#	Performance Indicator	
1	Number of High Priority referrals for substance abuse treatment per year	View
2	Maintain MOU between the Department of Mental Health and the Department of Corrections	View
3	Number served in the Community Mental Health Treatment (mental illness) and the MH4 (severe mental illness) programs per year	View

6	Tobacco Prevention / Cessation	SAP, SAT, MHS	SMI, SED, PWWDC, Other	View

#	Performance Indicator	
1	Annual Synar noncompliance rate is less than 20 percent	View
2	State plan for the development of a tobacco-free behavioral healthcare system	View
3	Number of nicotine replacement quit kit items distributed annually on Missouri college campuses	View

7	Recovery Support Services	SAT, MHS	SMI, SED, PWWDC, IVDUs, Other	View

#	Performance Indicator	
1	Status of certifciation standards for recovery support services	View
2	Number of contracts for Consumer Operated Service Programs (e.g. Drop-In Centers and Peer Support Warm Lines) for persons with mental illness	View
3	Number of S+C Housing Grants	View

	4	Status of certification standards for Family Support Provider programs		View
8	Medication Assisted Treatment for Addiction	SAT	PWWDC, IVDUs, HIV EIS, Other	View

#	Performance Indicator	
1	Number of consumers receiving medication therapy per year	View

9	Community Advocacy and Education	SAP, MHP	Other	View

#	Performance Indicator	
1	Number of local jurisdictions that have ordinances requiring a prescription for pseudoephedrine	View
2	Number of heroin trainings and education activities provided per year	View
3	Number of Mental Health First Aid Trainings per year	View
4	Number Trained in Suicide Prevention per year	View

10	Evidence-based Mental Health Practices	MHS	SMI, SED	View

#	Performance Indicator	
1	Number of Integrated Treatment for Co-Occurring Disorders programs	View
2	Number of Assertive Community Treatment (ACT) Programs	View
3	Number of Consumer Operated Services Programs (COSP)	View

11	IV Drug Users	SAT	IVDUs	View

#	Performance Indicator	
1	Number of IV drug users served in substance abuse treatment per year (assuming the same level of funding)	View
2	Percent of Block Grant Funded Providers Reporting Wait List Data	View

12	Substance-Abusing Pregnant Women and Women with Dependent Children	SAT	PWWDC	View

#	Performance Indicator	
1	Number of pregnant women and women with dependent children served in substance abuse treatment per year (assuming the same level of funding)	View

13	Tuberculosis-Related Services	SAT	TB	View

#	Performance Indicator	
1	Updated training curriculum on TB post-test counseling	View
2	Reports developed for TB referrals, testing, and post-test counseling services	View

14	Supported Employment	SAT, MHS	SMI	View

#	Performance Indicator	
1	Number of Individual Placement and Support Employment (IPS SE) programs	View

15	Mental Health Services for Transition-Aged Youth and Young Adults	MHS	SMI, SED	View

#	Performance Indicator	

	1	Number of Comprehensive trainings per year	View
	2	Number of Guardianship trainings per year	View

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$38,456,914		$103,778,959	$15,645,577	$75,703,541	$	$
a. Pregnant Women and Women with Dependent Children*	$2,880,796		$9,907,061	$253,413	$11,015,530		
b. All Other	$35,576,118		$93,871,898	$15,392,164	$64,688,011		
2. Substance Abuse Primary Prevention	$11,068,576			$2,415,012	$1,782,684		
3. Tuberculosis Services	$7,432		$14,367	$21	$11,045		
4. HIV Early Intervention Services							
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	$1,752,874			$1,959,206	$2,613,900		
11. Total	$51,285,796	$	$103,793,326	$20,019,816	$80,111,170	$	$

* Prevention other than primary prevention

footnote:
Missouri is not an HIV-designated state.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2014

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital				$11,238,892	$426,938,955		
6. Other 24 Hour Care				$16,361,537	$54,239,096		
7. Ambulatory/Community Non -24 Hour Care		$6,917,485	$581,435,430	$60,993,221	$82,831,979		
8. Mental Health Primary Prevention		$150,000		$1,462,332			
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		$392,638					
10. Administration (Excluding Program and Provider Level)		$392,638		$1,441,667	$1,459,740		
11. Total	$	$7,852,761	$581,435,430	$91,497,649	$565,469,770	$	$

* Prevention other than primary prevention

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			$	$
Specialized Outpatient Medical Services				
Acute Primary Care				
General Health Screens, Tests and Immunizations				
Comprehensive Care Management				
Care coordination and Health Promotion				
Comprehensive Transitional Care				
Individual and Family Support				
Referral to Community Services Dissemination				
Prevention (Including Promotion)			$	$
Screening, Brief Intervention and Referral to Treatment				

Brief Motivational Interviews				
Screening and Brief Intervention for Tobacco Cessation				
Parent Training				
Facilitated Referrals				
Relapse Prevention/Wellness Recovery Support				
Warm Line				
Substance Abuse (Primary Prevention)			$	$
Classroom and/or small group sessions (Education)				
Media campaigns (Information Dissemination)				
Systematic Planning/Coalition and Community Team Building(Community Based Process)				
Parenting and family management (Education)				
Education programs for youth groups (Education)				
Community Service Activities (Alternatives)				
Student Assistance Programs (Problem Identification and Referral)				
Employee Assistance programs (Problem Identification and Referral)				

Community Team Building (Community Based Process)				
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)				
Engagement Services			$	$
Assessment				
Specialized Evaluations (Psychological and Neurological)				
Service Planning (including crisis planning)				
Consumer/Family Education				
Outreach				
Outpatient Services			$	$
Evidenced-based Therapies				
Group Therapy				
Family Therapy				
Multi-family Therapy				
Consultation to Caregivers				
Medication Services			$	$

Medication Management				
Pharmacotherapy (including MAT)				
Laboratory services				
Community Support (Rehabilitative)			$	$
Parent/Caregiver Support				
Skill Building (social, daily living, cognitive)				
Case Management				
Behavior Management				
Supported Employment				
Permanent Supported Housing				
Recovery Housing				
Therapeutic Mentoring				
Traditional Healing Services				
Recovery Supports			$	$
Peer Support				
Recovery Support Coaching				

Recovery Support Center Services				
Supports for Self-directed Care				
Other Supports (Habilitative)			$	$
Personal Care				
Homemaker				
Respite				
Supported Education				
Transportation				
Assisted Living Services				
Recreational Services				
Trained Behavioral Health Interpreters				
Interactive Communication Technology Devices				
Intensive Support Services			$	$
Substance Abuse Intensive Outpatient (IOP)				
Partial Hospital				

Assertive Community Treatment				
Intensive Home-based Services				
Multi-systemic Therapy				
Intensive Case Management				
Out-of-Home Residential Services			$	$
Children's Mental Health Residential Services				
Crisis Residential/Stabilization				
Clinically Managed 24 Hour Care (SA)				
Clinically Managed Medium Intensity Care (SA)				
Adult Mental Health Residential				
Youth Substance Abuse Residential Services				
Therapeutic Foster Care				
Acute Intensive Services			$	$
Mobile Crisis				
Peer-based Crisis Services				

Urgent Care				
23-hour Observation Bed				
Medically Monitored Intensive Inpatient (SA)				
24/7 Crisis Hotline Services				
Other (please list)			$	$

footnote:

Missouri will continue to work on the necessary reports and crosswalks to pull information for this table and report in a future application.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$19,756,053	
2 . Substance Abuse Primary Prevention	$5,686,140	
3 . Tuberculosis Services	$3,716	
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	$900,485	
6. Total	$26,346,394	

* Prevention other than primary prevention

** HIV Early Intervention Services

footnote:
Missouri is not an HIV designated state.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$397,706	
	Selective	$177,236	
	Indicated		
	Unspecified		
	Total	$574,942	
Education	Universal	$610,481	
	Selective	$1,465,850	
	Indicated		
	Unspecified		
	Total	$2,076,331	
Alternatives	Universal	$33,939	
	Selective	$278,867	
	Indicated		
	Unspecified		
	Total	$312,806	
Problem Identification and Referral	Universal	$31,859	
	Selective	$47,348	
	Indicated		
	Unspecified		

	Total	$79,207	
Community-Based Process	Universal	$1,816,042	
	Selective	$173,668	
	Indicated		
	Unspecified		
	Total	$1,989,710	
Environmental	Universal	$229,361	
	Selective	$3,811	
	Indicated		
	Unspecified		
	Total	$233,172	
Section 1926 Tobacco	Universal	$32,798	
	Selective	$198	
	Indicated		
	Unspecified		
	Total	$32,996	
Other	Universal	$328,472	
	Selective	$58,504	
	Indicated		
	Unspecified		
	Total	$386,976	
Total Prevention Expenditures		$5,686,140	
Total SABG Award*		$26,346,394	
Planned Primary Prevention Percentage		21.58 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$2,763,354	
Universal Indirect	$717,304	
Selective	$2,205,482	
Indicated		
Column Total	$5,686,140	
Total SABG Award*	$26,346,394	
Planned Primary Prevention Percentage	21.58 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Expenditure Period Start Date: Expenditure Period End Date:

Targeted Substances	
Alcohol	
Tobacco	
Marijuana	
Prescription Drugs	
Cocaine	
Heroin	
Inhalants	
Methamphetamine	
Synthetic Drugs (i.e. Bath salts, Spice, K2)	
Targeted Populations	
Students in College	
Military Families	
LGBTQ	
American Indians/Alaska Natives	
African American	
Hispanic	
Homeless	
Native Hawaiian/Other Pacific Islanders	
Asian	
Rural	
Underserved Racial and Ethnic Minorities	

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$352,260			$352,260				
2. Quality Assurance								
3. Training (Post-Employment)	$2,500			$2,500				
4. Education (Pre-Employment)								
5. Program Development	$418,452	$15,000		$433,452				
6. Research and Evaluation	$262,154			$262,154				
7. Information Systems								
8. Enrollment and Provider Business Practices (3 percent of BG award)								
9. Total	$1,035,366	$15,000		$1,050,366				

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	$355,793
MHA Data Collection/Reporting	
Enrollment and Provider Business Practices (3 percent of total award)	
MHA Activities Other Than Those Above	
Total Non-Direct Services	$355793

Comments on Data:

footnote:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

Coverage of M/SUD Services

1. **Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?**

No changes are anticipated in terms of the State's Medicaid coverage of substance abuse or mental health services.

2. **Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?**

Missouri does not currently have plans to expand its Medicaid program nor is the state implementing a state health exchange. Provider staff have been trained on identifying and facilitating enrollment of individuals who meet basic categorical eligibility criteria for Medicaid benefits. In addition, consumers seeking services through the Department of Mental Health receive a Standard Means Test which includes questions regarding insurance.

3. **Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.**

Missouri does not currently have plans to expand its Medicaid program nor is the state implementing a state health exchange.

4. **Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?**

Missouri does not currently have plans to expand its Medicaid program nor is the state implementing a state health exchange.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Missouri does not currently have plans to expand its Medicaid program nor is the state implementing a state health exchange.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

D Health Insurance Marketplace

1. **How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?**

Missouri will not have a state-operated Health Insurance Exchange.

2. **How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?**

Missouri will not have a state-operated Health Insurance Exchange.

3. **How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?**

Provider staff have been trained on identifying and facilitating enrollment of individuals who meet basic categorical eligibility criteria for Medicaid benefits. In addition, consumers seeking services through the Department of Mental Health receive a Standard Means Test which includes questions regarding insurance.

4. **How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?**

Missouri will not have a state-operated Health Insurance Exchange. However, the provider coalition has taken significant steps toward preparing itself for health reform. Many providers are now nationally accredited, have purchased electronic health record systems, and are working to improve access.

5. **Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.**

For Substance Abuse Treatment in CY 2012, there were 16,574 consumers whose treatment services were paid by SABG funds and who were not enrolled in private insurance, Medicare, or Medicaid. The State does not anticipate the number for CY 2013 to be significantly different.

For Mental Health Treatment in CY 2012, there were 6,587 consumers whose treatment services were paid by MHBG funds and who were not enrolled in private insurance, Medicare, or Medicaid. The State does not anticipate the number for CY 2013 to be significantly different.

6. **Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.**

The State estimates that the numbers for CY 2014 and CY 2015 to be similar to that for CY 2013.

7. **For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.**

For Substance Abuse Treatment services in FY 2013, there were 187 provider sites (30 provider agencies) that have a CSTAR program. CSTAR is the only substance abuse treatment program that is Medicaid reimbursable.

For Mental Health services in FY 2013, there were 29 provider agencies that were enrolled in Medicaid with most delivering services at multiple sites.

8. **Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.**

Missouri currently does not have plans to expand Medicaid. At this time, estimates of number of providers enrolled in Medicaid are expected to remain the same as that of FY 2013.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Encounter/utilization/performance analysis; and
    f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

E Program Integrity

1. Does the state have a program integrity plan regarding the SABG and MHBG?

The Division of Behavioral Health (DBH) uses a Billing and Services Review (BSR) team to monitor compliance of services billed to the Purchase of Services (POS) billing category which is composed of block grant dollars and state funding. The BSR team is comprised of six (6) mental health professionals who conduct chart reviews at 80 contracted providers from the DBH, to assess compliance with program and certification standards. A further purpose of the reviews is to verify that services paid for by the DBH were actually provided and that the services are of high quality and appropriate to the needs of the consumer receiving the services.

2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

The Division of Behavioral Health (DBH) has a Compliance and Systems Management Coordinator who supervises the Billing and Services Review (BSR) team.

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:

a. Budget review;

The block grant budgets are reviewed annually. Each set-aside (5% Administration, 20% Prevention, 70% Treatment and 5% Prevention/Treatment) is budgeted separately. These annual budget reviews include review of all contracts to determine what, if any, changes are needed for the renewal and what contracts will be renewed; review of prior year expenditures and any additional funding needs over that amount; and consideration of funding available to establish new budgets. Once all contracts and obligations against those set asides are reviewed, funds are allocated to the treatment & prevention providers accordingly. Administration personal service (payroll) and expense & equipment budgets are established and expenditures are monitored at least monthly.

b. Claims/payment adjudication;

Specific block grant reporting categories are assigned within the state wide accounting system (SAM II) for each Block Grant set asides. Each reporting category has a budget established within SAMII that prevents the set-aside from being overspent. These reporting categories used for tracking the SAPT block grant with the SAMII system are as follows: BAM-administration; BGP-prevention, BGT-treatment. In addition, the division has established certain project codes to further distinguish SAPT block grant set-asides as they relate to Women & Children services and primary prevention activities. Routine reports are generated to ensure project codes are used appropriately. Any project code inadvertently missed is corrected with a journal voucher to add the project code in SAMII. All block grant expenditures are tracked in the statewide accounting system.

c. Expenditure report analysis;

Various reports have been established to monitor block grant expenditures, by the specific set asides, monthly or more often if needed.

d. Compliance reviews;

"Desk Audits" are completed throughout the year to monitor for compliance of selected services in scope of service delivery processes and documentation. A random selection of consumer charts is submitted by agencies for review. The Billing and Services Review (BSR) team reviews the charts for accuracy in service delivery, documentation and billing. Review findings are reported back to agencies along with technical assistance and training, if needed.

e. Encounter/utilization/performance analysis; and

Payer determination rules have been established in our Customer Information Management & Outcome Reporting (CIMOR) provider billing system to ensure proper spending of block grant funding.

f. Audits.

The Billing and Services Review (BSR) team is responsible for completing reviews (also referred to as billing audits) on a statewide basis. In terms of scope, the BSR team conducts site visits and chart reviews at 80 provider agencies across the state. The impact of the BSR team is that it assures state money is being spent appropriately and insures documentation in clinical records meets applicable rules and requirements in the state code of regulations, division contracts, and division policies.

4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

In order to determine service rates and package limits, the Division of Behavioral Health (DBH) seeks input from service providers and assesses current rates and package limits of comparable services and packages. In some grant programs such as Access to Recovery III where client targets are a requirement, those targets are also considered in the determination of service mix, rates, and packages.

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

Through Billing and Service Reviews (BSR), Safety and Basic Assurance Reviews (SBARS), and Certification surveys, the Division of Behavioral Health (DBH) assesses compliance with program requirements and standards. Through these surveys, agencies receive feedback regarding deficiencies and/or recommendations. DBH has implemented a Monitoring Database to track the monitoring process including scheduling of site visits, findings and deficiencies, action plan

requirements, action plan approval, certification status, and related communications and reports. DBH uses the survey outcomes to target technical assistance.

6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

Provider staff have been trained on identifying and facilitating enrollment of individuals who meet basic categorical eligibility criteria for Medicaid benefits. In addition, consumers seeking services through the Department of Mental Health receive a Standard Means Test which includes questions regarding insurance. Billing and Services Reviews (BSR) check the appropriateness of service billing.

The Department of Mental Health (DMH) information system links with the state Medicaid agency, MO Healthnet, to obtain the consumer's current Medicaid eligibility information. The system has an automatic sweep process that checks for the billing of Medicaid reimbursable services on Medicaid eligible consumers to ensure that such services are not billed to non-Medicaid funding sources including the Block Grant funds.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

a) What information did you use?

b) What information was most useful?

3) How have you used information regarding evidence-based practices?

a) Educating State Medicaid agencies and other purchasers regarding this information?

b) Making decisions about what you buy with funds that are under your control?

Footnotes:

F Use of Evidence in Purchasing Decisions

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

Yes, the Division of Behavioral Health (DBH) has specific staff that track and disseminate information regarding evidence-based and promising practices. Specific staff is designated to conduct fidelity reviews and to provide technical assistance and training on evidence-based practices. The evidence-based practices currently utilized are:

- Assertive Community Treatment (ACT)
- Integrated Treatment for Co-occurring Disorders
- Individualized Placement and Support Supported Employment
- Consumer Operated Service Programs (COSP)
- Dialectical Behavior Therapy
- Therapeutic Foster Care
- Medication Assisted Treatment (MAT)

DBH currently has a service code in the state rehab model (CPR) that allows certain children's EBP's to be reimbursed through Medicaid. A clinical review committee composed of state children's personnel and Community Mental Health Center clinical personnel review EBP's for determining their feasibility to be billed to rehab model.

In addition, it is an expectation that clinical treatment and prevention staff share evidence-based practices information as appropriate during other agency reviews and contacts.

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

Yes, the Division of Behavioral Health (DBH) used information regarding evidence-based practices in purchasing and policy decisions.

a) What information did you use?

For policy decisions, DBH has used the SAMHSA EBP Toolkits and the Dartmouth models when available, e.g., Integrated Treatment for Co-Occurring Disorders and Consumer Operated Service Programs. For Supported Employment, DBH is following the Individualized Placement and Support model from Dartmouth. For Dialectical Behavior Therapy, DBH has remained faithful to the Marsha Linehan, Ph.D., model. DMH has used state and national outcome data for Assertive Community Treatment.

b) What information was most useful?

All of the evidence-based practice information is useful.

3) How have you used information regarding evidence-based practices?

a) Educating State Medicaid agencies and other purchasers regarding this information?

The Division of Behavioral Health (DBH) has worked closely with MO HealthNet, the Medicaid agency, to implement evidence-based practices. For example, a collaborative document for DBH treatment providers was created called *Appropriate Use of Community Support and Targeted Case Management in Workplace Environments*. The document is intended to support the Individualized Placement and Support model.

b) Making decisions about what you buy with funds that are under your control?

DBH, working closely with MO HealthNet, the state Medicaid agency, has created specific billing codes to support services for Integrated Treatment for Co-Occurring Disorders, Assertive Community Treatment and Dialectical Behavior Therapy. DBH has used best practice information in educating MO HealthNet on the provision of rehabilitation services for transitional age youth within the school setting.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

G Quality

1) **What additional measures will your state focus on in developing your State BG Plan (up to three)?**

Missouri will further study its potential measures for barometric reporting.

2) **Please provide information on any additional measures identified outside of the core measures and state barometer.**

Missouri will further study its potential measures for barometric reporting.

3) **What are your states specific priority areas to address the issues identified by the data?**

Missouri will further study its potential measures for barometric reporting.

4) **What are the milestones and plans for addressing each of your priority areas?**

Missouri will further study its potential measures for barometric reporting.

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

H Trauma

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

Certification for both mental health and substance use disorder treatment programs require comprehensive assessment be conducted that assists in ensuring an appropriate level of care, identifying necessary services, and developing an individualized treatment plan. Trauma awareness and sensitivity is a key value of the Missouri Department of Mental Health (DMH), and accordingly, the service providers shall ensure that services delivered are guided by DMH's position statement on services and supports for trauma survivors. Guiding principles for trauma-informed services shall include:

a) providing an environment that ensures physical, emotional and interpersonal safety;
b) engaging the consumer as an equal partner;
c) promoting consumer empowerment;
d) utilizing staff that is knowledgeable and trained on trauma-related issues;
e) providing services in a holistic, contextual, and strengths based manner;
f) integrating services on an individual, system-wide, policy, and funding level; and
g) educating stakeholders and the community at large about the needs of trauma survivors.
h) Contractual requirements specify that substance use disorder treatment providers must:
i) engage families in treatment to the fullest extent possible,
j) provide substance abuse treatment at levels of intensity that meet individual and family needs,
k) provide for treatment of co-occurring mental disorders,
l) assess for trauma-related issues and provide trauma specific services, and
m) provide effective care to people from different cultures in the communities it serves.

Further, treatment that addresses multiple domains of the consumer's life, including substance abuse, mental illness, trauma, criminality, skill deficits, family conflict, employment or academic problems, and lack of social support for recovery must be provided. Further, trauma-specific services, Trauma Individual Counseling and Trauma Group Education, are available on the service menu and must be delivered by appropriately trained staff.

For programs providing services for mental illness, contractual requirements specify that programs must incorporate trauma-informed approaches into service delivery that will actively consider the likelihood of consumer's experience of trauma, as well as abide by the guiding principles for trauma-informed services.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

Contractual requirements specify that substance use disorder treatment providers must:

a. engage families in treatment to the fullest extent possible,
b. provide substance abuse treatment at levels of intensity that meet individual and family needs,

c. provide for treatment of co-occurring mental disorders,
d. assess for trauma-related issues and provide trauma specific services, and
e. provide effective care to people from different cultures in the communities it serves.

Further, treatment that addresses multiple domains of the consumer's life, including substance abuse, mental illness, trauma, criminality, skill deficits, family conflict, employment or academic problems, and lack of social support for recovery must be provided. Further, trauma-specific services, Trauma Individual Counseling and Trauma Group Education, is available on the service menu and must be delivered by appropriately trained staff.

For programs providing services for mental illness, contractual requirements specify that programs must incorporate trauma-informed approaches into service delivery that will actively consider the likelihood of consumer's experience of trauma, as well as abide by the guiding principles for trauma-informed services.

3. Does your state have any policies that promote the provision of trauma-informed care?

Trauma awareness and sensitivity is a key value of the Department of Mental Health, and accordingly, the service providers shall ensure that services delivered are guided by the DMH's position statement on services and supports for trauma survivors. Guiding principles for trauma-informed services shall include:

a. providing an environment that ensures physical, emotional and interpersonal safety;
b. engaging the consumer as an equal partner;
c. promoting consumer empowerment;
d. utilizing staff that is knowledgeable and trained on trauma-related issues;
e. providing services in a holistic, contextual, and strengths based manner;
f. integrating services on an individual, system-wide, policy, and funding level; and
g. educating stakeholders and the community at large about the needs of trauma survivors.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

For SUD treatment providers using the trauma-specific codes, an evidence-based model must be used. There are evidence-based models for both children and adult. For the mentally ill, doing therapy that is trauma-specific must be done in accordance with an evidence-based model that is age-appropriate. Available in the state are the following recognized models: TF-CBT; Dialectical Behavior Therapy; Prolonged Exposure; EMDR; and, PCIT.

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

There are several entities that provide training on trauma. In addition to the Department of Mental Health (DMH) one of the largest conduits of training is through the Child Advocacy Center of Greater St. Louis which is part of the National Child Traumatic Stress Network. In addition to providing training on trauma focused Evidence-Based Practices, they provide awareness training as well as training on the Child Welfare Trauma Toolkit.

DMH provides training on trauma along a continuum not only to providers but to other community and state entities. The continuum is as follows:

- Trauma Aware – Didactic training usually 60-90 minutes in length often provided within a conference venue or stand alone. This training introduces the concept of trauma, prevalence and its impact. This training has been provided to a variety of audiences including, but not limited to child welfare, juvenile justice, school administrators and counselors, public health, early childhood, law enforcement. DMH has also provided an asynchronous 30-minute webinar on trauma awareness that is available on the public DMH website
- Trauma Responsive – This is a 6-hour interactive training that goes beyond trauma awareness to teach individuals how to interact with and/or respond to an individual with a trauma history. This training discusses triggers, re-traumatization, symptoms, services/supports, secondary/vicarious trauma, and trauma-informed organizations. A manual has been developed for this training with plans to progress to increasing capacity by growing the number of trainers. The manual includes information as noted above. Specific, unique modules will be added for different populations such as homeless, substance abuse, juvenile justice etc. This training to date has been conducted with the Mental Health Commission, multiple state department managers, peer and family support specialists and treatment family home providers.
- Trauma informed – DMH is entering its fifth year of its Trauma Informed Early Adopters initiative. This is an organizational change process that an organization goes through that addresses policy, practice, staff and environmental issues related to trauma. Organizations are led through a self-assessment process at their own pace with both general and topic specific consultation provided. To date five community mental health centers, Cottonwood Residential Treatment Center (DMH operated children's residential program) and Division of Youth Services (post adjudication delinquency commitments state department) have been trained as early adopters. The current focus is now on creating trauma informed communities bringing in multiple non-traditional partners.
- Trauma Specific Interventions – DMH has sponsored training on Trauma-Focused Cognitive Behavior Therapy (TF-CBT), Dialectical Behavior Therapy and Eye Movement Desensitization & Reprocessing (EMDR)

DMH has worked with multiple partners to insert trauma training into several grants and projects such as Project LAUNCH (early childhood health promotion/prevention), MIECHV (early

childhood home visiting), Crossover Youth (child welfare and juvenile delinquency) and Early Childhood Comprehensive System grant.

DMH also is sponsoring the 2nd Annual Trauma Roundtable that brings leaders in different areas of trauma care. Representatives of the following settings are included: secure forensic hospital, HeadStart, Child Advocacy Center, women's substance abuse treatment, community mental health centers, adult club houses, private psychiatric hospitals, child welfare and Department of Corrections. Finally, the Department of Mental Health hosts an annual training event targeted to providers of behavioral health and development disability services. This conference has consistently devoted a track of the multi-day conference to trauma, offering the latest information on interventions, models and evidence-based practices.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. [42,43] Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

I Justice

1. **Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?**

The Missouri legislature did not pass legislation authorizing the expansion of Medicaid.

2. **What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?**

For individuals with mental disorders, in most cases a sentencing assessment report (SAR) is done if ordered by the sentencing judge. At the time of the SAR interview, all criminogenic needs and risks are discussed and evaluated including mental health and substance abuse. Tools used are the Interview and Assessment Worksheet, the SAR Risk Factor, and the Static 99R for sex offenders.

Substance abuse is assessed using the Screening for Alcohol and Chemical Abuse (SACA) score, criminal history, treatment history, file material, or other evidence of substance-abusing behavior. These assessments guide placement and treatment services within the Department of Corrections.

The Risk and Needs Assessment (RANT) is the assessment/screening tool used on all drug-involved offenders prior to placement in drug court. This assessment tool provides court personnel with a classification tool to determine the appropriate level and type of criminal justice supervision and treatment services to efficiently utilize treatment drug court funds. The RANT includes 19 questions related to empirically identified, criminogenic risks and clinical needs of drug-involved offenders. Offenders are assigned to one of four quadrants with two scales, one of risk and one of need, based upon their RANT score.

Missouri offers several types of specialized courts: adult drug court, juvenile drug court, family treatment court, mental health treatment court, DWI court, veteran's treatment court and re-entry treatment court.

The Missouri Juvenile Offender Classification System represents Missouri's effort to create an objective based decision-making strategy for managing youthful status and law violators referred to juvenile and family courts. The Office of State Courts Administrator (OSCA) developed the classification system pursuant to Subdivision 4 & 5 of Sections 211.326.1, 211.141.4, and 211.141.5 RSMo. Supp.1995 of the Missouri Juvenile Code.

The complete classification system includes an empirically validated risk assessment for estimating a youthful offender's relative likelihood of future delinquency, a classification matrix, which links the level of risk with offense severity to recommend graduated sanctions, and a needs assessment for identifying the underlying psychosocial needs of youth. The system also includes a method for assessing juvenile offender adjustment to supervision through the use of a

supervision reassessment form, and a set of web-based reports on the risk and needs characteristics of youthful offenders.

Thirty-five of Missouri's 45 judicial circuits are currently using the system for the purpose of case management decision-making and workload estimation, 20 of which utilize Missouri's automated case management system (JIS), which provides for an automated version of the classification system.

Specifically for youth, the DMH allocates a small amount of funds to designated community mental health centers to partner with juvenile courts to assess, identify and expand quality mental health services to children jointly served by the two entities. The goals are to improve access and coordination between the courts, mental health and schools; provide early intervention services to decrease risk of juvenile offending; improve the prognosis for recovery for our youth through earlier identification and intervention; address the special needs of children; and promote public safety. The impact can be extensive for the community, schools, and families and in addressing public safety issues. These projects also provide a model for partnerships within the community to meet the needs of youth and special needs populations.

The Missouri Crossover Youth Policy Team is assisting several communities interested in enhancing their ability to meet the needs of crossover youth by implementing a Crossover Youth Practice Model. For purposes of the pilot project, the term "crossover youth" is defined as youth who are adjudicated or receiving services from either the child welfare or juvenile justice system and who are at risk of becoming dually involved due to a subsequent delinquent offense or finding of child abuse/neglect, as well as youth who are dually adjudicated or simultaneously receiving services or supervision from both the child welfare and juvenile justice systems.

Crossover youth in Missouri are typically known and served by multiple state and local agencies, yet they continue to progress deeper into the juvenile justice system or cross back and forth between systems. To better meet the needs of crossover youth, the Center for Juvenile Justice Reform at the Georgetown University Public Policy Institute and Casey Family Programs developed a practice model to help agencies strengthen their organizational structures and implement or improve practices that directly affect the outcomes for crossover youth. Key elements include:

- creation of a process for identifying crossover youth at the point of risk for crossing over,
- ensuring that staff exchange information in a timely manner,
- including families in all decision-making aspects of the case,
- ensuring that foster care bias is not occurring at the point of detention or disposition, and
- maximizing the services utilized by each system to prevent crossover from occurring.

3. **Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use**

disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

The Department of Mental Health has been actively involved in prison reentry since partnering with the Department of Corrections in 2002 as part of a National Institute of Corrections (NIC) Transition from Prison to Community Initiative (TPCI) demonstration project. This partnership continued beyond the TCPI and is now known as the Missouri Reentry Process. The Department of Mental Health provides a representative on the statewide Missouri Reentry Process Steering Team that meets regularly to assist local and statewide agencies with prison reentry.

The Division of Behavioral Health (DBH) works closely with the Department of Corrections (DOC). Regular joint meetings that include staff from DOC's Offender Rehabilitation Unit, Probation and Parole, and DBH are held to address opportunities for system enhancement, ideas for addressing challenges, and the development of initiatives for offenders in reentry or diversion from prison. Specific initiatives that have been successfully implemented include referral processes that ensure individuals with serious mental illness and/or substance use disorders that are considered high risk for repeated criminal activity and/or relapse have immediate access to community-based services.

We also have a strong "problem-solving" court system in Missouri which includes adult and juvenile treatment courts as well as mental health, family, veterans, DWI, and reentry courts. Staff of the Division of Behavioral Health regularly interacts with the Office of the State Courts Administrator (OSCA) to ensure that individuals involved in the various treatment courts have appropriate services available to them through the state's network of community-based providers. Treatment court participants are a target population and receive priority consideration for placement in services based upon their individual needs.

Additionally, the Department, through the Coalition of Community Mental Health Centers, partners with the Department of Corrections and the Division of Probation and Parole to provide mental health and substance abuse services to offenders under supervision in the community upon referral from a Parole Officer.

4. **Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?**

The Missouri legislature did not pass legislation authorizing the expansion of Medicaid so there will be no expanded enrollment. See the other responses relative to the coordination of care.

5. **What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?**

Cross trainings have been provided in the partnership described above between the providers in the Coalition of Community Mental Health Centers and the Division of Probation and Parole. These trainings have occurred primarily at the local level between the individuals working directly together and also at a summit hosted by the Division of Probation and Parole for the community providers and field officers. Additionally, the Missouri Department of Mental Health hosts a spring training conference that devotes an entire track to those consumers involved with the criminal justice system and the conference is well-attended by DOC staff. Likewise, there is an annual drug court conference held in Missouri each spring that is sponsored by the National Association of Drug Court Professionals, that is well-attended by providers of behavioral health services.

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

J Parity Education

1. **How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?**

The Division of Behavioral Health (DBH) does not currently have a communication plan for parity education. However, communication goals regarding the importance of taking care of mental health needs are included in the Department's strategic plan.

2. **How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?**

Advocacy organizations like the Coalition for Community Mental Health Centers can play an important role in educating providers. Individual community support specialists play a role in assisting the individuals served in the public mental health system to be educated about their benefits. The Department of Mental Health will continue to work with stakeholders to increase awareness regarding parity.

3. **What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?**

Training the general public through programs such as Mental Health First Aid can educate the general public on the importance of behavioral health treatment for those in need and that health insurance programs are required to cover such treatment through the parity laws. The Department of Mental Health, partnering with the Missouri Institute for Mental Health, provides trainings throughout the state.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

6. Describe how your behavioral health providers are screening and referring for:

   a. heart disease,

   b. hypertension,

   c. high cholesterol, and/or

   d. diabetes.

Footnotes:

K Primary and Behavioral Health Care Integration Activities

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

The Department of Mental Health with the assistance of consultants funded by Missouri Foundation for Health has collaborated with The Department of Social Services (MO HealthNet Division), the Missouri Primary Care Association (PCA), the Missouri Coalition of Community Mental Health Centers (Coalition) and various stakeholders to develop a Health Home model for Missouri. The components of the Health Homes include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care including follow-up from inpatient and other settings;
- Patient and family support;
- Referral to community and support services; and
- Use of health information technology to link services.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

The Disease Management 3700 Project (DM 3700) is a collaborative project between the Department of Mental Health and MO Health Net. The project targets high cost Medicaid clients who have impactable chronic medical conditions. The Department of Mental Health has agreed to contact these identified persons, provide outreach and engagement, enroll them in the Community Psychiatric Rehabilitation (CPR) program, and provide necessary services, focusing on community support/case management to coordinate and manage their medical and psychiatric conditions. Our services and interventions have reduced the cost to the state by providing care and treatment and improving outcomes for the identified clients. While the outreach and initial enrollment will be through the Division of Behavioral Health (DBH), formerly the Divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services, and the CPR program, if the client indicates a substance use disorder, they may be referred to the DBH Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs as appropriate.

The Missouri Department of Mental Health supports development of a comprehensive, coordinated system of care of children, youth and their families who need psychiatric, developmental and/or substance abuse treatment services and supports. A system of care is a comprehensive array of mental health and other necessary services which are organized in a coordinated way to meet the multiple and changing needs of children, youth and their families. However, a system of care is more than an array of services, it is a philosophy about the way in which children, youth and families receive services. Partnerships at all levels between families, providers, communities, regions and the state are fundamental to an effective system of care. The following are the values and principles that define the philosophy and lay the foundation for system of care service delivery. Core Values include the following:

- The system of care shall be child-specific and family-focused, with the needs of the child and family dictating the types and mix of services provided;
- The system of care shall be community based, with the focus of services, as well as management and decision-making responsibility resting at the community level;
- The system of care shall be culturally competent, with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve;
- The system of care shall nurture the development of natural supports for the child and family in their own home and community;
- The system of care shall assure access, quality, respect, choice, accountability and strive for positive outcomes;
- The system of care must support collaboration, partnership and integration at all levels – child and family provider, community, regional and state.

The Missouri Department of Mental Health has begun utilizing Care Management Technologies (CMT) which is a top provider of evidence-based behavioral health analytics and decision support tools, and has been partnering with the State of Missouri since 2003. Through their clinical expertise, data analytics, and advanced technology, CMT offers powerful solutions that deliver clinical insight and the latest best-practice data to clinicians at the point of treatment. By compiling and analyzing comprehensive data sets from multiple sources, CMT helps clients improve prescribing, increase adherence, and better coordinate care for their costliest, most complex members, resulting in improvements in provider prescribing practice, reductions in ER visits and hospitalizations, and significant behavioral pharmacy cost avoidance.

CMT Solutions in Missouri include:

- Behavioral Pharmacy Management (BPM) for Individual Prescribers
- Behavioral Pharmacy Management (BPM) for Agencies
- Opioid Prescription Intervention (OPI)
- Antipsychotic Prevalence in Children (APRx)
- Disease Management Reports
- Medication Adherence Reports
- Diabetes Initiative

The Missouri Commission on Autism Spectrum Disorders has begun their initiative for a State Plan Development in which the commission will make recommendations for developing a comprehensive, quality statewide plan for an integrated system of training, treatment, and services for individuals of all ages with autism spectrum disorder. All Committees:

- Shall study and report on means for developing a comprehensive, coordinated system of care delivery across the state to address increased and increasing presence of ASD and ensure resources are created, well-utilized, and spread across the state.

- Shall plan for evaluating regional services areas and capacity, outlining personnel and skills within service areas, other capabilities that exist, and unmet resource needs.
- May explore need to create interagency councils and evaluate current councils to ensure comprehensive, coordinated system care for individuals with ASD.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

Yes, as noted previously the Department of Mental Health with the assistance of consultants funded by Missouri Foundation for Health has collaborated with the Missouri Primary Care Association (PCA), the Missouri Coalition of Community Mental Health Centers (Coalition) and various stakeholders to develop a Health Home model for Missouri. Selected Community Mental Health Centers (CMHC), Federally Qualified Health Centers (FQHC) and public entity primary care clinics are the providers of the Health Homes. Both the Primary Care and CMHC Health Homes encourage and provide technical assistance in enhancing the relationships between the FQHCs, community health centers, other primary care practices, and the behavioral health providers.

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

The Department of Mental Health (DMH) developed a ***Missouri Plan for Living Tobacco Free – Recovery and Prevention for Our Mental Health & Wellness***. DMH believes that overall health is essential to mental health and that recovery includes wellness. Reducing or preventing tobacco-related disparities among consumers of DMH services is critical to consumers' experiencing optimal mental health and wellness. The goals and strategies in this plan will reduce and prevent tobacco dependence and contribute to the recovery of persons receiving services for developmental disabilities, mental illness and substance use disorders from DMH.

The plan was developed thanks to funding from the Missouri Foundation for Health and a group of committed and passionate mental health consumers and professionals. Implementation of the plan will result in a reduction of tobacco-related disparities and improved mental health and wellness among consumers of DMH services. The plan includes tobacco policies and practices and strategic planning process for consumers and agencies to prevent or become tobacco free. DBH has trained 35 Tobacco Treatment Specialist (TTS). These are experts in providing tobacco treatment and using nicotine replacement therapy (NRTs). Three of our agencies (Crider, Comtrea and Queen of Peace) have purchased and are using CO meters with our consumers.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

Each client enrolled in a Community Mental Health Center – Healthcare Home (CMHC-HCH) receives a health screen by a Nurse Care Manager (NCM) that includes a set of questions which screen for tobacco use, type, history, amount, duration, attempts to quit and whether or not the client would like to address smoking cessation in their treatment. The Division of Behavioral Health (DBH) also tracks smoking use among clients on the Metabolic Syndrome Screening (MSS) tool. All CMHC-HCH clients receive an MSS annually as well as all CMHC clients on anti-psychotic medication. MSS data is entered into the Care Management Technologies database, Pro-Act, which allows the DBH to track smoking statistics and outcomes among our population.

Many training initiatives have taken place in Missouri's CMHCs. Motivational Interviewing training was provided to all CMHC HCHs. The Coalition and PCA have offered the Freedom from Smoking curriculum to all Missouri Health Homes. Many NCMs are providing this curriculum to classes of clients at their CMHCs.

The Department of Mental Health provided wellness coaching training to all CMHCs and some substance use treatment providers. Wellness Coaching is a set of techniques designed to focus on achieving and maintaining wellness, particularly the physical dimension. Wellness coaching helps people to brainstorm ideas, and problem solve actions and co-create a wellness goal and plan. The coach helps people find their own solutions by asking questions that give them a better understanding of their situation.

6**. Describe how your behavioral health providers are screening and referring for:**

a) **heart disease,**
b) **hypertension,**
c) **high cholesterol, and/or**
d) **diabetes.**

Community Mental Health Centers (CMHC) are required to annually conduct the Metabolic Syndrome Screening for clients who are receiving an antipsychotic medication and all clients in Healthcare Homes (HCH). This annual screening monitors the risk factors of obesity, hypertension, hyperlipidemia, and diabetes. Licensed practical nurses or registered nurses have key functions including taking and recording vital signs, conducting lab tests to assess lipid levels and blood glucose levels and/or HgbA1c; arranging for and coordinating lab rests to assess lipid levels, blood glucose levels, and/or HgbA1c; and record those results. Providers have been provided funds to purchase Cholestech LDX analyzer or other machines approved by the Department. Providers are also expected to complete metabolic syndrome screening and health screenings for all consumers being provided health home services. Any concerns from the results of either screen are communicated to primary care providers for treatment follow-up and coordination of care.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

L Health Disparities

1. **How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?**

Consumer demographics are captured by the Department of Mental Health's (DMH) Consumer Information Management Outcomes and Reporting (CIMOR) system. These demographic variables include preferred language, race, ethnicity, gender identity (ISO 5218), age, veteran status, and hearing status. CIMOR does not currently collect sexual preference information other than sexual history for the HIV/STD/TB risk assessment for individuals seeking substance abuse treatment.

2. **How will you identify, address and track the language needs of disparity-vulnerable subpopulations?**

The state of Missouri contracts with Language Select which can provide written and spoken translation as needed. Language Select provides interpretations in 200 languages. Language Select monitors customer language requests to recruit additional languages as needed. The Department of Mental Health's (DMH) Office of Deaf Services (ODS) is responsible for consultation and technical assistance to DMH facilities and contracted providers delivering behavioral health services to eligible individuals who are deaf, hard of hearing or from cultural minority groups. The ODS also establishes minimum competencies for behavioral health interpreters, consistent with the federal Culturally Linguistically Appropriate Services Standards. Client complaints and grievances received either by DMH's Office of Constituent Services or by the provider organization are reviewed by DMH clinical staff for issues with cultural competency.

3. **How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?**

The Missouri Department of Mental Health (DMH) Values Statement on Respected Unique Participant Characteristics states, "Missourians participating in mental health services are valued for their uniqueness and diversity and respected without regard to age, ethnicity, gender, race, religion, sexual orientation, or socio-economic condition." Core standards require that services be delivered in a manner that is responsive "to each individual's age, cultural background, gender, language and communication skills, and other factors, as indicated" (9 CSR 10-7.010). In addition, programs that provide meals must have a written plan to ensure that menus are responsive "to cultural and religious beliefs of individuals" (9 CSR 10-7.080). The Division of Behavioral Health (DBH) requires through contract language that contractor staff be competent in the cultural, racial, and ethnic patterns of the geographic area being served. Interpreting services are provided to individuals in treatment whose preferred language is a language other than spoken English.

About 27 percent of the consumers accessing behavioral health treatment funded through the DBH are of minority race and/or ethnicity. This is a higher percentage than compared to that of

the general population in the State. About 19 percent of Missouri's general population is of a minority racial or ethnic group. DBH contracts with several prevention, treatment, and recovery support providers that specifically target minority populations and underserved populations. The state of Missouri contracts with Language Select which can provide written and spoken translation as needed. The Department's Director of Deaf Services also provides consultation and assistance to DMH facilities and providers delivering behavioral health services to eligible individuals who are Deaf, hard of hearing or from cultural minority groups.

DBH is a provider of cultural competency training for the state's behavioral health treatment and prevention workforce. Cultural competency training is included in DMH's annual Spring Training Institute which is attended by approximately 800 behavioral health and human service professionals. In recent years, Spring Training Institute workshops have included sessions: "Behavioral Ethno-geriatrics" (2013), "Ethics and Cultural Competence" (2013), "Female Veterans in the Criminal Justice System" (2013), "Understanding Deaf Culture" (2013), "Elder Fraud: New Threats, Prevention, and Ethical Practice" (2013), "What It Feels Like to Go To Combat…and Its Aftermath" (2013), "Homelessness and Women – Research, Co-Occurring Disorders and Clinical Intervention" (2013), "One World, Many Cultures, Where Do I Start? Cultural Competency in Mental Health Care" (2012), "Becoming More Culturally Responsive in a Multi-Cultural Workplace" (2012), "Cultural Diversity in Counseling" (2012), "Clinical Consideration in the Treatment of PTSD in Military Veterans" (2012), "Connect. Accept. Respond. Empower. – How to Support LGBTQ Youth" (2011), "Substance Abuse Treatment for Lesbian, Gay Bisexual, and Transgender Individuals" (2011), "Cultural Competence: Working with Diverse Populations" (2010), "Mental Health Needs of the Veterans Returning from Iraq" (2010), "Healthcare for Homeless Veterans" (2008), "Intervention and Prevention of Substance Abuse within Urban and Rural Communities (2008), "Can You Hear Me Now? Clinical Perspective on Working with Adolescents Who are Deaf" (2008), "Suicide Prevention Strategies and Clinical Intervention for the Veteran Population" (2008), "The Meaning of RESPECT" (2008). (The 2009 Spring Training Institute was cancelled due to a state budget crisis.)

4. How will you use Block Grant funds to measure, track and respond to these disparities?

All populations whose treatment services are funded with Block Grant funds are registered in the Department of Mental Health's Consumer Information Management Outcomes and Reporting (CIMOR) system. CIMOR also captures data on client demographics, services, and outcomes. Demographic data is collected for prevention services via the Minimum Dataset (MDS).

Core standards require that services be delivered in a manner that is responsive "to each individual's age, cultural background, gender, language and communication skills, and other factors, as indicated" (9 CSR 10-7.010). In addition, programs that provide meals must have a written plan to ensure that menus are responsive "to cultural and religious beliefs of individuals" (9 CSR 10-7.080). The Division of Behavioral Health (DBH) requires through contract language that contractor staff be competent in the cultural, racial, and ethnic patterns of the geographic area being served. Interpreting services are provided to individuals in treatment whose preferred language is a language other than spoken English. The Department of Mental Health's Office of Deaf Services (ODS) is responsible for consultation and technical assistance to DMH facilities and contracted providers delivering behavioral health services to eligible individuals who are

deaf, hard of hearing or from cultural minority groups. The ODS also establishes minimum competencies for behavioral health interpreters, consistent with the federal Culturally Linguistically Appropriate Services Standards. Client complaints and grievances received either by DMH's Office of Constituent Services or by the provider organization are reviewed by DMH clinical staff for issues with cultural competency. Cultural competency training is included in the DMH's annual Spring Training Institute which is attended by approximately 800 behavioral health and human service professionals.

The Division of Behavioral Health (DBH) contracts with several treatment, recovery support, and prevention providers that specifically target minority populations and underserved populations. DBH has implemented a school-based Prevention, Intervention and Resources Initiative (SPIRIT) that provides prevention curricula of proven effectiveness at reducing alcohol and other drug use and reducing incidences of violent behavior among children in grades kindergarten through 12. SPIRIT currently operates in four school districts across the state. These districts were identified as high-risk districts based on juvenile justice referrals, school drop-out rates, and students receiving reduced or free lunches. DBH also funds selective prevention services through eight community-based agencies as well as the Missouri Alliance of Boys and Girls Clubs. These services target youth experiencing academic failure located in communities identified as low income. DBH provides selective prevention services through the Leadership Education and Advocacy for Deaf (L.E.A.D.), the statewide provider for Deaf and Hard of Hearing. DBH funds Partners in Prevention (PIP), Missouri's higher education substance abuse consortium. PIP serves approximately 16,400 African-American students, 3,400 Asian students, 10,300 LGBTQ students, and 20,400 students who have a disability.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

Recovery

Indicators/Measures

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

Yes, the Missouri Division of Behavioral Health (DBH) has adopted SAMHSA's recovery definition and principles. These principles and associated definition was reviewed and accepted by the State Advisory Council on Comprehensive Psychiatric Services.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

Yes, the Department of Mental Health (DMH) and its associated Division of Behavioral Health have hired people in recovery for leadership roles in the DMH Office of Constituent Services, as Co-chairs of the Consumer Conference planning group, and as a Peer Services Program Specialist with oversight of the Consumer Operated Services Program.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Yes, the Division of Behavioral Health (DBH) continues to promote person-centered, individualized, participant-directed care. Trainings and written memorandums have provided guidance.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

Yes, peer support, recovery support, wellness coaching, drop-in centers and warm lines, and family support providers are all included in Missouri's system of care.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Yes, the Division of Behavioral Health's (DBH) state plan does include peer-delivered services with a particular focus on services to Veterans, people with a history of trauma, families/significant others, and deaf individuals.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

Yes, the Division of Behavioral Health (DBH) has provided training to the community mental health centers that hire Certified Missouri Peer Specialists.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

The state has binding competitive bid contracts for the Consumer Operated Services Programs. The Division of Behavioral Health has conducted fidelity reviews in the past and is making plans to start this process again with trained peer evaluators.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

The Division of Behavioral Health has promoted the SAMHSA approved wellness coaching training statewide over the past year.

Involvement of Individuals and Families

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

The State Advisory Councils for Alcohol and Drug Abuse (ADA) and for Comprehensive Psychiatric Services (CPS) have members that are individuals in recovery and family members. The divisions formerly known as the Division of Alcohol and Drug Abuse and Division of Comprehensive Psychiatric Services (CPS) have integrated into one Division of Behavioral Health (DBH). The DBH Director made the decision to maintain two separate State Advisory Councils at his time.

The duties of the State Advisory Council for CPS meet the federal requirements to:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

A majority of the council members are individuals in recovery and family members of individuals in services.

The councils are required by state statute to collaborate with the department in developing and administering a state plan on comprehensive psychiatric and alcohol or drug abuse services. The councils shall be advisory and shall do the following:

(1) Promote meetings and programs for the discussion of reducing the debilitating effects of mental disorders or mental illness and alcohol or drug abuse and disseminate information in cooperation with any other department, agency or entity on the prevention, evaluation, care, treatment and rehabilitation for persons affected by mental disorders or mental illness and alcohol or drug abuse;
(2) Study and review current prevention, evaluation, care, treatment and rehabilitation technologies and recommend appropriate preparation, training, retraining and distribution of manpower and its resources in the provision of services to persons affected by mental disorders or mental illness and alcohol or drug abuse through private and public residential facilities, day programs and other specialized services;
(3) Recommend what specific methods, means and procedures should be adopted to improve and upgrade the comprehensive psychiatric and alcohol and drug abuse service delivery system for citizens of this state;
(4) Participate in developing and disseminating criteria and standards to qualify comprehensive psychiatric and alcohol and drug abuse residential facilities, day programs and other specialized services in this state for funding by the department.
(5) Provide oversight for suicide prevention activities.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

The State Advisory Councils provide opportunities for individuals and family members issues on the system level to be addressed. Individual meetings at the treatment provider sites allow for the individual and family members to address individual issues. Specific projects have multiple opportunities for individuals and family members to voice concerns about the behavioral health system, e.g., Missouri Recovery Network meetings, Healthy Transitions Initiative for emerging adults grantee meetings, etc.

The Real Voices, Real Choices consumer and family conference provides many opportunities for addressing concerns. Participants have direct access to DMH leadership and many positive comments have been received regarding this opportunity.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

Treatment providers have received state sponsored training on person-centered planning. Certified Missouri Peer Specialists and Missouri Recovery Support Specialist-Peers are working in the behavioral health system. Wellness Recovery Action Plan trainings, Wellness Coaching Training and Peer Support Whole Health & Resiliency Training have been provided to the peer specialists.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

The Department of Mental Health (DMH) supports NAMI of Missouri with multiple contracts for Family-to-Family and NAMI Basics courses, training for mental health professionals, parent ombudsman services, and Mental Health First Aid. DMH supports Mental Health America of the Heartland to provide the BRIDGES training and support groups.

DMH supports the Missouri Recovery Network. The Missouri Recovery Network (MRN) is a statewide organization that advocates for addiction treatment and recovery support throughout Missouri. The network consists of members who are in personal recovery, family members, friends, allies and other supportive people who help to identify barriers to recovery and offer solutions which will enhance recovery for a greater number of Missourians.

The state employs a Family Support Specialist to promote training for Family Support Providers and their supervisors in the community mental health centers.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

The Missouri Department of Mental Health (DMH) works diligently to meet the mandates of the Supreme Courts Olmstead decision. The mental health system strives for a full array of housing options tailored to the needs of the individual. Since 1994, the DMH Housing Unit has assisted Missourians challenged by mental illnesses, substance abuse/addictions and developmental disabilities in obtaining and maintaining safe, decent and affordable housing options that best meet their individual and family needs. The DMH Housing Unit believes that housing is a key to helping Missourians with disabilities and their families attain self-determination and independent living. DMH has a seven member housing team that coordinates the HUD funding for housing statewide. The Housing Unit housed more than 3,227 individuals in FY 2012. The total budget

is $17,522,784 funded by 40 HUD grants. There is detailed information online at http://dmh.mo.gov/housing/index.htm

Additional funding for housing is provided through the support community living program and the Access to Recovery (ATR) III grant funding. Treatment providers have sought outside funding to build, maintain and house individuals served in community housing. Every effort is made to move individuals out of long term inpatient care into community settings. Missouri has an effective Pre-Admission and Resident Review (PASRR) process in place. The department is currently reviewing the new PASRR guidance in order to further expand transitions from nursing facilities to community based housing and supports.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

Treatment providers hire Community Support Specialists to work with individuals to find appropriate housing and a supportive community. Treatment provider staff includes Peer Support Specialists that can assist the individuals served in finding and maintaining natural supports in the community.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

Evidence Based Prevention and Treatment Approaches for the SABG

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

The Missouri Division of Behavioral Health (DBH) is supported by a Research and Statistics unit and also contracts with the Missouri Institute for Mental Health (MIMH) at the University of Missouri-St. Louis and the Office of Social and Economic Analysis (OSEDA) at the University of Missouri-Columbia for data and research support. The DBH Research unit annually compiles and publishes behavioral health statistics in its Status Report on Missouri's Substance Use and Mental Health. In addition, the DBH Research unit tracks prevention outcomes for budget and grant reporting. MIMH provides expertise in behavioral health research, evaluation, and training and has provided management and/or evaluation support to grant projects: Strategic Prevention Framework State Incentive (SPF-SIG) Grant (2004-2009), Screening Brief Intervention Referral and Treatment Grant (SBIRT) (2008-2013), Mental Health Transformation Grant (2006-2011), the Partnership for Success Grant (2012-2015) as well as other ongoing projects including the Missouri Student Survey and the School-based Prevention Intervention and Resource Initiative (SPIRIT). OSEDA also provides data and reporting support for the Missouri Student Survey.

The DBH Research Coordinator and the Prevention Director are both represented on the State Epidemiology Outcomes Workgroup (SEOW). Missouri's SEOW, initially established under the SPF-SIG was revitalized under the SEOW contract and currently receives support from the Partnership for Success Grant. The mission of Missouri's SEOW is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;
- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

Missouri's SEOW is chaired by a Research Assistant Professor at MIMH. Membership includes data experts from mental health, social services, public safety, health, education, and the judicial system. The SEOW workgroup continues to assess data gaps, enhance capacity to use behavioral health data, promote data driven decision-making, increase dissemination of data and analyses, promote common data standards, and increase data collaborations. The SEOW generates regular work products including county-level epidemiology profiles and hot topic briefs. The SEOW with support from the DBH Research unit has developed and continues to maintain a web-based querying tool to facilitate use of behavioral health data.

DBH's priorities, goals, and performance measures are established in the Strategic Plan for Prevention (2010-2015):

http://dmh.mo.gov/docs/ada/Progs/Prevention/StrategicPlanforPrevention2010.pdf.
The state plan was drafted by the DBH Prevention Director under the guidance of the DBH Management Team and the State Advisory Council for Alcohol and Drug Abuse (SAC-ADA). The SAC-ADA serves as an advisory body to DBH. Performance measures established by the state plan are tracked via a dashboard report that is integrated into the web-based querying tool. The dashboard report is in the process of being retooled.

DBH contracts with 11 Regional Support Centers (RSCs) to provide technical assistance to 160 community coalitions focused on substance abuse prevention. As a part of the Strategic Prevention Framework model, the RSCs conduct a needs assessment to identify the types of primary prevention services for each community. The needs assessment data sources include state, county and local data for consumption patterns, consequences of use and risk and protective factors. The RSCs use multiple data for the assessment. Examples include but are not limited to the following:

- Missouri Behavioral Health Epidemiologic Workgroup (MO-BHEW) data querying website: **http://dmh.mo.gov/seow,**
- Missouri Status Report on Missouri's Substance Use and Mental Health: http://dmh.mo.gov/ada/rpts/status.htm,
- Missouri Information for Community Assessment (MICA): http://health.mo.gov/data/mica/MICA/,
- Annie Casey Foundation Kids Count: http://datacenter.kidscount.org/;
- Missouri Office of Social and Economic Analysis Reports and Applications: http://www.oseda.missouri.edu/,
- Missouri Department of Elementary and Secondary Education School District Reports: http://mcds.dese.mo.gov/quickfacts/SitePages/DistrictInfo.aspx, and
- local data when available from schools and law enforcement sources.

The primary prevention programs for the community are identified through the community needs assessment.

The Missouri Student Survey (MSS) is a significant data source for prevention planning. The Division of Behavioral Health replicated the survey first conducted by Research Triangle Institute for the SAMHSA/CSAP funded Missouri State Prevention Needs Assessment Grant. Since 2000, the survey has been available for Missouri students in grades 6 through 9. The MSS collects data for substance use consumption patterns, consequences of use, and risk and protective factors. Participating schools and their communities review the survey results to assist program selection. The annual Missouri Student Survey Report is published at: http://dmh.mo.gov/ada/rpts/survey.htm

Missouri's School-based Prevention Intervention and Resource Initiative (SPIRIT) provides evidence-based prevention programs to four school districts in Missouri. Data has been used with the SPIRIT model since implementation in 2002. After meeting the risk factors of: 1) at least 60% of students receiving free/reduced lunch, 2) standardized tests scores below state average, 3) ATOD use above state average, 4) high drop-out rate, and 5) high number of referrals to juvenile authorities, the high-risk population schools were then matched to evidence-based substance abuse prevention programs. The SPIRIT model also includes an evaluation component. Each school's needs determine the evidence-based program and any supplemental

lessons implemented. Missouri's SPIRIT program received the 2010 SAMHSA Science and Service Award. SPIRIT reports and related-information are published at: http://dmh.mo.gov/ada/progs/SPIRIT.htm

Missouri funds a statewide consortium of 21 colleges and universities, Partners in Prevention (PIP) to address underage and binge drinking on Missouri campuses. Data from the Missouri College Health Behavior Survey (MCHBS): http://pip.missouri.edu/data.html and the Missouri College Student Veterans Assessment (MCSVA): http://pip.missouri.edu/research.html are reviewed by each campus to identify their specific needs. PIP also provides technical assistance to campus communities involving alcohol access laws.

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

Statewide Substance Abuse Prevention Network – DMH has created a prevention network to address alcohol, tobacco, and other drug use in the community through advocacy and community education. Missouri's 160 **community coalitions** and the 11 **Regional Support Centers** work to change community norms, policy, and substance availability in support of creating healthy and safe communities across the state. The Regional Support Centers, in collaboration with the community coalitions, develop, implement, and evaluate a comprehensive strategic plan with identified target outcomes based on community needs. The Regional Support Center in Eastern Missouri is leveraging SAPT Block Grant prevention dollars with funding from United Way and other community partners to conduct a comprehensive campaign on heroin and other opiate drug use. The **Statewide Training and Resource Center** (STRC) provides resources, training, and technical assistance for the Regional Support Centers, coalitions, and other direct prevention providers. The STRC presents a number of statewide workshops throughout the year and also holds a statewide prevention conference.

The **School-based Prevention Intervention and Resources Initiative (SPIRIT)** program supports implementation of prevention curricula of proven effectiveness at reducing alcohol and other drug use and reducing incidences of violent behavior among children in grades Kindergarten through 12. Age- and grade-appropriate curricula are taught, screening and referral services are available, and support for prevention activities throughout the school are provided. SPIRIT currently operates in four school districts across the state: Carthage R-IX, Knox Co. R-1, New Madrid Co. R-1, and Ritenour in St. Louis. Programs implemented include: PeaceBuilders, Second Step, Too Good for Drugs, and Project Towards No Drug Abuse. Specific program goals are to: 1) delay onset and decrease use of alcohol, tobacco and other drugs; 2) improve overall school performance; and 3) reduce incidents of violence, including bullying. All aspects of the SPIRIT project are evaluated by a professional prevention evaluation team. The school districts participating in SPIRIT were identified as high-risk districts based on the number of youth for each district, the number of referrals to juvenile authorities, school drop-out rates, and the number of students receiving reduced or free lunches.

Partners in Prevention (PIP) is Missouri's higher education substance abuse consortium comprised of 21 public and private college and university campuses across the state that work to reduce rates of harmful and dangerous drinking on campuses. The coalition also focuses on other problematic health behaviors such as high risk driving behaviors and problem gambling. In addition, support and services are provided to campuses across the state to prevent suicide and support positive mental health among college students. Brief Alcohol Screening and Intervention for College Students (BASICS) is being implemented to reduce risky behaviors and harmful consequences of alcohol abuse, as well as the Student Alcohol Responsibility Training (START) program which assists students in planning and hosting a successful, fun, and safe event of any kind. Members of the PIP coalition meet monthly for training and network opportunities and host a statewide prevention conference each spring called Meeting of the Minds. Each college and university involved with PIP is required to write and implement a strategic plan. To identify progress of their goals, and to obtain data for program planning and implementation, each campus conducts the Missouri College Health Behavior Survey (MCHBS), an annual, online survey implemented each spring semester since 2007.

High Risk Youth Programs in various parts of the state provide evidence-based prevention services to youth and families with high risk factors for substance use because of living in low-income and/or minority communities, family history of abuse, or because they are experiencing academic failure.

The programs and strategies implemented by these agencies include: After school mentoring programs for predominantly African-American 12-15 year old youth in urban St. Louis who are at risk for substance use due to poor social or economic factors; Celebrating Families curriculum for families in which one or both parents have a serious problem with alcohol or other drugs and in which there is a high risk for domestic violence, child abuse, or neglect; the How to Cope program for those ages 18 and up which offers education and support to individuals who are affected by another person's abuse of alcohol or drugs; and the Lincoln University Youth Development Kids' Beat program which enriches and empowers youth in geographically and economically depressed areas, focusing on substance abuse prevention through leadership skill development, conflict resolution, self-esteem, interpersonal relationships, application of knowledge and resources, and cultural experience. The Leadership Education and Advocacy for the Deaf (L.E.A.D.) Institute provides education and research for enhancing socio-emotional development, effective communication, and leadership skills to individuals who are deaf and hard of hearing. The Missouri Alliance of Boys and Girls Clubs, consisting of 13 sites across the state, serves high risk youth between the ages of 5 and 18. The sites implement SMART Moves, which helps young people learn to resist alcohol, tobacco and other drugs and avoid premature sexual activity, and MethSMART which is a program designed to help youth understand how to achieve life goals without succumbing to the threat of drugs, particularly methamphetamine.

The **Missouri Student Survey (MSS)**, jointly administered by the Departments of Mental Health and Elementary and Secondary Education, assesses substance use and related behaviors among 6^{th} – 12^{th} graders attending public schools across the state. The Regional Support Centers and coalitions use data from the MSS for their community needs assessment and planning.

Prevention Evaluation supports all prevention services through the provision of data for assessing prevention needs and program effectiveness. The Missouri Student Survey is included among the evaluation activities. The Behavioral Health Data Tool website provides users with the ability to access and analyze community-level data to support strategic planning and implementation of targeted interventions. The State Epidemiology Outcomes Workgroup (SEOW) ensures a data-driven process and helps increase data capacity.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

The Missouri Division of Behavioral Health (DBH) works collaboratively with other state agencies and non-profit organizations to maximize prevention resources. Interagency workgroups with DBH representation include:

- Council for Adolescent School Health;
- Missouri Coordinated School Health Coalition;
- Missouri Alliance for Drug Endangered Children;
- Juvenile Crime Enforcement Coalition for Missouri School Violence Hotline;
- Task Force on the Prevention of Sexual Abuse of Children;
- Missouri HIV/STD Prevention Community Planning Group;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Children in Nature Committee (to increase education about nature and positive experiences with the outdoors);
- Missouri Behavioral Health Epidemiology Workgroup;
- Show Me Response (disaster & emergency coordination);
- Smoking Cessation Planning Workgroup;
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Mental Health First Aid Advisory Council; and the
- Missouri Alliance to Curb Problem Gambling.

DBH prevention funds are used to leverage other prevention resources in the community. For example, SAPT Block Grant funds in addition to funds from other prevention providers including United Way have been used to implement a comprehensive campaign to stop the rising number of heroin-related deaths in Eastern Missouri. Missouri's higher education consortium, Partners in Prevention (PIP), receives funding from the SAPT Block Grant prevention set-aside with supplemental funding from the Missouri Division of Highway Safety, the Youth Suicide Prevention Grant, the Enforcing Underage Drinking Laws Grant, and the Garrett Lee Smith Memorial Act Campus Prevention Grant. PIP serves

The Missouri Division of Behavioral Health (DBH) provides training, education, and technical assistance through the Missouri Statewide Training and Resource Network (STRC). Training and technical assistance are provided to Regional Support Center staff and community leaders to promote community development, accountability, and targeted prevention initiatives based on the Center for Substance Abuse Prevention's (CSAP) best practices program recommendations. The STRC, with assistance from the Southwest Regional Expert Team, presents statewide and

regional workshops throughout the year. The STRC plans and coordinates the annual Statewide Prevention Conference. The 2012 Conference "Missouri Champions of Prevention" included workshops on strategic planning, use of data products, care for drug endangered children, suicide prevention, building sustainable community partners, program evaluation, in addition to other topics. The conference was attended by about 200 prevention professionals and other interested parties. In addition, the Department of Mental Health Annual Spring Training, attended by over 900 behavioral health and human service professionals, provides a prevention track.

All funded prevention agencies must be certified by the Department of Mental Health http://www.sos.mo.gov/adrules/csr/current/9csr/9csr.asp. Prevention staff must maintain a minimum prevention credential, Missouri Substance Abuse Prevention Associate (MSAPA), through the Missouri Substance Abuse Professional Credentialing Board (MSAPCB) http://www.msapcb.com/.

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

The outcome data collected by the state is determined by the Department of Mental Health's Strategic Plan for Prevention:

.http://dmh.mo.gov/docs/ada/Progs/Prevention/StrategicPlanforPrevention2010.pdf

Statewide prevention goals include:

- Reduce binge drinking among Missouri's youth and young adults;
- Delay onset of first use of alcohol and marijuana;
- Reduce the use of alcohol and marijuana among youth in the past 30 days;
- Increase the number of youth who perceive risk/harm of alcohol, cigarettes, marijuana and other drugs;
- Reduce the prescription drug misuse among young and older adults;
- Reduce smoking and other tobacco use among Missouri's youth;
- Decrease methamphetamine labs;
- Reduce substance use among pregnant women; and
- Continue to meet the requirements of the Synar amendment for reducing sale and distribution of tobacco products to individuals under the age of 18.

Data measuring binge drinking among youth and young adults is obtained from the Missouri Student Survey and the National Household Survey on Drug Use and Health, state and sub-state estimates. The Missouri Student Survey also provides data on the onset of first use of alcohol and marijuana; current use of alcohol and marijuana; risk/harm perception of alcohol, cigarettes, marijuana, and other drugs; current use of cigarettes and other tobacco products; and non-medical use of prescription drugs. The Missouri Department of Public Safety provides data on methamphetamine laboratory incidents by county which can be aggregated up to the service area, regional, and state levels. Non-medical use of prescription drugs for adults age 26 and older is available from the National Household Survey on Drug Use and Health. DBH, in collaboration with the SEOW, continues to explore data sources to measure substance use among pregnant

women. These data sources include the Pregnancy Risk Assessment Monitoring System (PRAMS) of which Missouri is a participating state: http://apps.nccd.cdc.gov/cPONDER/default.aspx?page=main. In addition, DBH obtains reportable incidents of maternal use of illicit drugs from the Missouri Patient Abstract System. DBH is the agency responsible for conducting Missouri's Synar survey and for reporting the state's non-compliance rate.

The outcome data are tracked in the state dashboard report which is currently being reworked and will be integrated into the web-based data querying tool. In addition, provider reports are being developed to be used as a tool to assess strategic planning at the provider level. These reports will show providers how their area's outcome data compares to that for the state. Providers will have flexibility to incorporate other initiatives into their plans provided it can be supported by a data-driven process rather than antidotal evidence.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

Missouri uses an outcomes-based process for prevention planning through the Strategic Prevention Framework (SPF). The Regional Support Centers (RSC) are required to develop an annual Strategic Plan utilizing the SPF. The Strategic Plan is based upon findings from their Community Needs Assessment which identifies the needs and determines the capacity of resources in the community. The Needs Assessment incorporates local, state, and regional data to identify the incidence and prevalence of alcohol and other drug use and their consequences, specific cultural and demographic characteristics of the target community, and risk and protective factors. The Needs Assessment is then utilized to develop, implement and evaluate a comprehensive Strategic Plan with identified target outcomes, identified community readiness to change, identified gaps in community resources, and includes an assessment of the specific coalition needs. The Strategic Plan also includes proposed evidence-based strategies to be implemented, expected population-level outcomes, prevention training and education to be provided, a training and technical assistance plan for coalitions, and an implementation timeline.

The training and technical assistance plan includes goals, objectives, timelines and milestones that the RSCs will achieve in order to address the identified needs of the coalitions and the community. Trainings are designed to address specific needs identified and pre and post assessments are administered to evaluate the effectiveness of the training provided.

The RSCs submit monthly progress reports that provide progress towards outcomes, and includes technical assistance provided to coalitions and partnerships, trainings provided to coalitions, summary of the training evaluations, community education events conducted, and direct prevention services provided. An annual report is also required which demonstrates that the RSCs and their coalitions have achieved their prevention outcomes.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

In FY 2012, $5,585,010 or 21.3 percent of Missouri's Block Grant expenditures was for primary prevention. Of the primary prevention expenditures, $381,776 or 6.8 percent was for payroll and operational expenses such as travel, supplies, and office-related expenses at the state agency. The remaining 93.2 percent was for contracted prevention services.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

The prevention set aside is used to implement evidence-based practices, environmental strategies and the Strategic Prevention Framework. The following is a list of programs and strategies used:

- Strategic Prevention Framework Model (12)
- Peace Builders (3)
- Second Step (4)
- Project Towards No Drug Abuse(3)
- Too Good For Drugs(3)
- Meth SMART (Skills Mastery and Resistance Training) (1 Statewide @13 sites)
- SMART Moves(Skills Mastery and Resistance Training)(1 Statewide @13 sites)
- Creating Lasting Family Connections (CLFC) (1)
- Celebrating Families (1)
- Mentoring (3)
- Teen Institute(1 Statewide)
- How to Cope (1)
- BASICS (Brief Alcohol Screening and Intervention of College Students)(1 Statewide @21 sites)

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are required to use their 5 percent set-aside of their Mental Health Block Grant (MHBG) allocation to support "evidenced-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders."

Please note that this set aside funding is dedicated to provide supports and services for those "with early serious mental illness" and not for primary prevention or preventive intervention for those at risk of serious mental illness. States are encouraged to fund programs to meet the needs of persons with early psychotic disorders, specifically first episode psychosis. States may address these needs either through enhancing existing program activities or development of new activities.

Describe the states assessed need for the target population and proposed evidence-based programs, an explanation for why this population was chosen, a description of planned activities and a budget showing how the 5% will be spent.

Footnotes:

Evidence-Based Prevention and Treatment Approaches for the MHBG (5 percent)

Needs Assessment: The prevalence of serious mental illness (SMI) among U.S. young adults age 18 to 25 is estimated to be 4.1 percent (Substance Abuse and Mental Health Services Administration, 2013). Applied to the respective population in Missouri's Southwest Block Grant Planning Region, an estimated 4,309 young adults (age 18-25) have SMI. The prevalence of serious emotional disturbance (SED) among U.S. teens age 16 to 17 is estimated at 10.4 percent (Mark, T.L. and Buck, J.A., 2006). Applied to the respective population in Missouri's Southwest Block Grant Planning Region, an estimated 2,544 teens (age 16-17) have SED. To estimate the number with psychosis, prevalence of psychotic disorders is determined for those populations in Southwest Region who were served by the Missouri Division of Behavioral Health (DBH). The grouping of ICD-9 codes for the psychosis group is taken from the Healthcare Cost and Utilization Project (H-CUP) (Agency for Healthcare Research and Quality, 2004). In FY 2013, 59.2 percent of SED teens age 16 to 17 served by DBH had a psychotic disorder. Similarly, 76.6 percent of SMI young adults age 18 to 25 served by DBH had a psychotic disorder. These percentages are applied to the general population of SED (age 16-17) and SMI (age 18-25) in the Southwest Block Grant Planning Region. The estimated size of the priority population is then 1,506 youth age 16-17 and 3,301 youth age 18-25 – a total of 4,807. These are transition age youth with psychotic disorders who reside in the Southwest Block Grant Planning Region.

	Age 16-17		
Missouri Block Grant Planning Region	2012 Population	Estimated SED (10.4%)	Estimated Psychotic Disorder (59.2%)
Southwest	24,460	2,544	1,506

	Age 18-25		
Missouri Block Grant Planning Region	2012 Population	Estimated SMI (4.1%)	Estimated Psychotic Disorder (76.6%)
Southwest	105,097	4,309	3,301

Psychotic disorders are generally rare for individuals under the age of 14. The onset of schizophrenia is generally between ages 15 and 35 although lower onset ages are associated with a family history of the disorder. Research also suggests that age of onset may be lower for males (McGorry, P.D., Purcell, R., Goldstone, S., & Amminger, G.P., 2011).

Current System: In FY 2013, the Missouri Division of Behavioral Health (DBH) provided community-based mental health treatment to 1,470 individuals age 16 to 25 who resided in the Southwest Block Grant Planning Region. Of these, 1,059 had a psychotic disorder. The treatment gap is then 3,748 (4,807– 1,059). Transition aged youth may be served in the youth and/or adult programs depending upon the individual's assessed level of development. In either case, an individualized, wraparound process provides individualized care management. The DBH funds Assertive Community Treatment (ACT) for individuals with serious and persistent

mental illness. In Southwest Region, the DBH contracts with two agencies to provide ACT. Missouri has modified its ACT model to accommodate transition age youth. The multi-disciplinary ACT team includes a psychiatrist, a vocational specialist/education specialist, a substance abuse therapist, a community support worker, a psychiatric nurse, and a peer specialist. McGrew and Danner (2009) found that young people age 18 to 25 participating in ACT for transition age youth had improved adult daily living skills, were more likely to be working, less likely to be homeless, and less likely to be convicted of a misdemeanor at one-year follow-up.

The DBH has implemented Supported Employment (SE) for individuals whose mental illness has presented a barrier to engaging in meaningful work. DBH contracts with three providers in Southwest Region who are required to partner with the Division of Vocational Rehabilitation to offer evidence-based supported employment services. Program fidelity is monitored. Research has shown that young adults with psychiatric disorders, in particular, can benefit from SE programs (Burke-Miller, J., Razzano, L.A., Grey, D.D., Blyler, C.R., & Cook, J.A., 2012). In support of enhancing employment options for consumers, the Department of Mental Health Employment Workgroup has facilitated the development of benefits planning training materials and a web-based tool "Disability 101". The tool (http://mo.db101.org/) is made publicly available to anyone needing to know how employment will impact their disability benefits.

The National Institute of Mental Health (NIMH) has funded one *Recovery After an Initial Schizophrenia Episode* (RAISE) site in Southwest Region. RAISE is a NIMH research project that is implementing a coordinated specialty care model similar to the Assertive Community Treatment but specific to early onset schizophrenia. RAISE is not listed in SAMSHA's National Registry of Evidence-based Programs and Practices (NREPP) but is considered a "promising" practice (SAMHSA, 2014). The RAISE site in Southwest Region ended service delivery in March 2014 but continues evaluation activities. Outcome data are not yet available.

Priority Population: The priority populations for the Block Grant five percent set-aside are youth age 16 to 17 with SED and a psychotic disorder and young adults age 18 to 25 with SMI and a psychotic disorder. The geographic area to be served is the Southwest Block Grant Planning Region: (http://www.samhsa.gov/data/NSDUH/substate2k10/RegionDefinitions/NSDUHsubstateRegDefs2010.htm). Included are 21 rural counties. All 21 counties in this region are designated as mental health shortage areas by the Health Resources and Services Administration (HRSA, 2014). The estimated numbers of transition age youth with SED/SMI and a psychotic disorder in the Southwest Block Grant Planning Region is 4,807.

Inclusion Criteria	
Age range	16-25 years
Diagnosis	SED (age 16-17) w/ psychosis disorder or SMI (age 18-25) w/ psychosis disorder*
Geography	Resides in Southwest Region

*psychosis diagnostic group as defined by Healthcare Cost and Utilization Project (H-CUP).

Proposed Evidence-Based Program (EBP) – <u>Coordinated Specialty Care for Transition Age Youth</u>

CSC Program: Missouri will implement a Coordinated Specialty Care (CSC) Program in Southwest Region for the treatment of transition age youth with priority given to those with early onset psychosis. CSC services will include empirically-supported interventions including 1) cognitive/behavioral psychotherapy, 2) family education/supports, 3) case management, 4) supported employment/education, and 5) medication/primary care supports. Psychotherapy provides goal-oriented treatment designed to maximize the strengths and to reduce behavior problems and/or functional deficits stemming for the existence of a psychotic disorder that interferes with a consumer's personal, familial, vocational, and/or community adjustment. Family education and supports are designed to improve knowledge, coping skills, communication, problem solving, and goal setting for the family unit. Case management includes the arrangement and coordination of an individual's treatment and rehabilitation needs, as well as other medical, social, and educational services and supports to ensure continuity of services. The functional components of case management include assessment, care planning, referral/linkage, and monitoring/follow-up. With supported employment, direct job coaching/support services are provided to the consumer at the community work site with the goal of assisting the consumer in choosing, getting, and keeping competitive employment. Specific supported employment services include, but are not limited to, meeting at the work site with the employer for needed interventions; mediation between the individual and the employer, and helping the consumer learn specific job-related tasks. Medication services include the assessment of the need for medications, the prescription of medications, and ongoing management of a medication regimen. Management services include monitoring lab levels; coordination of medication needs with primary care, consumers, and their families; consumer and family education regarding medications; and monitoring physician orders for treatment modifications requiring consumer/family education.

The CSC program will provide a recovery-oriented approach that includes person-centered planning and shared decision-making. Program expectations are that CSC treatment will be time-limited (2-3 years) and linkages to community supports will be established to maintain recovery during and beyond treatment. Treatment may be extended in the CSC program, as clinically appropriate, using a step-down approach with eventual transition to traditional mental health services in the community.

The program will employ a multi-disciplinary team approach to provide flexible, individualized care in community settings of the consumer's choice. The team will include professionals with expertise in psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The team leader will be responsible for the consumer's overall treatment plan and programming. Team caseloads will be relatively small (25-35 consumers or less) to ensure that teams have sufficient time to adequately provide individualized wraparound. Teams will meet regularly and frequently to maintain focus on consumer recovery and support program fidelity. Ongoing training will be provided to CSC staff.

CSC Staff Development: CSC staff development will include both team training and specialty training. Team training will address the team approach in serving transition age youth with

emphasis on early onset psychosis. Topics may include: adolescent brain development, first episode psychosis, mental health recovery, person-centered treatment planning, wraparound concept, individualizing care, characteristics of effective teams, effective communication, team member roles and responsibilities, and ensuring accuracy and quality in clinical documentation. Specialty training will focus on the skills and interventions required by CSC model. Topics may include: psychopharmacology, supported employment, peer support, relapse prevention planning, trauma-based care, wellness management, and family engagement. Specialty training will provide continuing education for specialists; a broader perspective for non-specialists; and cross-training, as appropriate.

CSC Provider: Missouri will contract with Burrell Behavioral Health in Springfield, Missouri to implement the CSC program. Burrell is a community-based non-profit organization that provides a wide range of behavioral healthcare services and is contracted with the Missouri Department of Mental Health (DMH) for treatment of substance abuse disorders, mental illness, and developmental disabilities. Burrell is the administrative agent for a seven county area of Southwest Region. As such, the agency is responsible for determining eligibility and providing mental health services to qualifying residents. DMH also contracts with Burrell to staff Access Crisis Intervention (ACI) Hotlines for areas in Central Region (10 counties) and Southwest Region (7 counties). These hotlines ensure that individuals in crisis have access to mental health professionals 24 hours per day and 7 days per week. Burrell is CARF accredited for community integration, mental health day treatment, mental health outpatient treatment, community housing, health home, substance abuse residential treatment, and substance abuse outpatient treatment (CARF, 2014). Burrell employs a community mental health liaison (CMHL), which is funded by DMH, to assist courts and law enforcement with behavioral health issues of those who come to the attention of the justice system. Burrell has a research unit in its organization to support data collection and program evaluation activities. Burrell is contracted with DMH for Assertive Community Treatment (ACT). Burrell's ACT team provides training and consultation to the agency's other sites for the treatment of psychosis. The agency also has been a NIMH-funded RAISE site (services ended March 2014 and evaluation is ongoing). One of the lessons learned during Burrell's experience with RAISE is the importance of Supported Employment for transition age youth.

Planned Activities: For the FY 2014 award, Missouri will implement Coordinated Specialty Care (CSC) Program in the Southwest Block Grant Planning Region. The implementation plan is as follows:

Task	**Responsible Party**	**Tentative Completion**
Determine geographic boundaries	DMH	7/23/2014
Identify overall program structure	DMH, in consultation with SAMHSA & provider	7/23/2014
Define clinic population and eligibility criteria	DMH	7/23/2014
Establish funding/operating budget	DMH	7/23/2014
Establish a referral protocol	DMH & provider	9/1/2014
Set and finalize clinical treatment	DMH	9/1/2014

Task	Responsible Party	Tentative Completion
definitions and rates		
Assess staffing requirements	DMH & provider	9/1/2014
Establish programmatic oversight rules	DMH & provider	9/15/2014
Develop standards for team functioning	DMH & provider	9/15/2014
Develop training plan	DMH in consultation with provider	9/15/2014
Recruit staff	Provider	11/1/2104
Train staff	DMH & provider	ongoing after 11/1/2014
Modify billing system	DMH	12/1/2014
Develop data collection plan and fidelity measures	DMH & provider	12/1/2014
Enroll consumers	Provider	ongoing after 1/1/2015
Monitor consumer enrollment and service utilization	DMH & provider	ongoing after 1/1/2015
Monitor program fidelity	DMH & provider	ongoing after 1/1/2015
Develop and program data reports	DMH	2/1/2015

Block Grant Five Percent Set-aside Budget:

FY 2014 Award:

Activity	Budget for Block Grant 5% Set-Aside
Coordinated Specialty Care Staff Development	$50,000
Staffing Start-up Costs	$228,426
Coordinated Specialty Care Services for Transition Age Youth	$114,212
Total for FY 2014 Award	**$392,638**

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IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

Missouri currently has 17 fully operational System of Care (SOC) sites around the state with several other communities submitting proposals to be considered SOC sites. The Division of Behavioral Health (DBH) has a full time person that is designated to providing/arranging technical assistance and oversight of these sites.

In FY 2013, the sites were invited to a statewide SOC conference*: Expanding the View; Linking System of Care and Public Health.* Conference sessions included team development, goal setting and action planning. A post conference evaluation was distributed to the SOC teams. Data gathered from the work sessions was used to identify themes directed towards follow up technical assistance to local teams, as well as areas for the policy directives. All teams were contacted and offered specific follow up assistance based on their input. Six webinars were conducted in fall 2012 in direct response to the evaluation data. As a resource, the webinars have been posted on the SOC website.

Since June of 2013, DBH has distributed funds around the state to the SOC sites to increase capacity for training, family participation and leadership, community awareness and partnership, and strategic planning. Sites submitted proposals outlining their specific community needs as a prerequisite to receiving the funds. These proposals will be used to help measure outcomes over the course of the next year. In addition, DBH has set aside funds for ongoing evaluation of these sites.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

Over the last several years, the Divisions of Behavioral Health (DBH) and Developmental Disabilities (DD) have examined the challenges of meeting the needs of children and adolescents with co-occurring developmental disabilities and emotional and/or substance abuse disorders. Because of the complexity of the issues related to co-occurring disorders, no one service system can adequately meet the needs of the children. In order to address this issue and improve services for children and families across the spectrum, the Divisions have developed a protocol, or a process, for providing the most complete services for children and adolescents who fall into this category. "Protocol for Coordinated Service Planning for Children with Co-Occurring Disorders" has been implemented throughout the system following a series of regional trainings in June, 2013. The protocol seeks to address several goals, including the following:

- To assure that children/youth with co-occurring disorders receive the most complete array of services available;
- To assist families in accessing services from any Department of Mental Health division as easily as possible;
- To assure smooth transition between Divisions as the needs of a child/youth change; and
- To assist the child/youth and their family with transition from child to adult services.

The Divisions are planning follow-up webinars, regional trainings and meetings to assist in the ongoing implementation of the protocol.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

On June 17-18, 2013 the Health Care Foundation of Greater Kansas City sponsored a brainstorming and strategic planning meeting for department directors and their key executive staff from the Departments of Corrections, Elementary and Secondary Education, Health and Senior Services, Mental Health, Social Services, and the Office of Administration. The meeting provided opportunity for the departments to brainstorm the possibility of developing an interdepartmental initiative for young children (ages 6 and under) who are at high risk due for ongoing traumatic events in their lives, including abuse or neglect, the incarceration of a caregiver, or caregivers with conditions that could dramatically impact the health, safety and development of a child, such as substance abuse problems or severe mental illness. The meeting was a rare opportunity for department directors and their staffs to have the time to share perspectives and seek consensus on what they believe are the critical issues facing young, high risk children in Missouri and how state departments might work together to develop and test an interagency initiative to address these issues. Meetings have been scheduled to pursue this agenda. Plans are to invite the State Budget Office to join future meetings.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

The Missouri Division of Behavioral Health (DBH) has an ongoing commitment to providing opportunities for its service providers to receive training in evidence based practices. Several examples of this effort are as follows:

- The Coordinating Board for Early Childhood Mental Health is developing educational opportunities for medical professionals, mental health professionals and early care and education providers. Within the FY 2014, they will be offering training to mental health providers, including DBH's community mental health centers personnel. Training will include:
    - Face to face regional training on social and emotional development and provision of mental health services to infant, toddlers, and young children and their caretakers
    - Regional learning collaborative led my mental health professionals with expertise in the field of early childhood mental health will follow this training to support a level of guidance and collegial support for work with this population.

- DBH will sponsor five statewide trainings in Mental Health First Aid (MHFA), the first of which is scheduled for August 21-22.

MHFA is a groundbreaking public education program that helps people identify, understand, and respond to signs of mental illness. The 8-hour course teaches participants how to talk to individuals in crisis and connect them with the help they need. At least one of these trainings will be focused on children's MHFA.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

The Division of Behavioral Health (DBH) is responsible for monitoring the performance and compliance of its community based provider agencies and conducting reviews of those agencies. As part of the monitoring process, the DBH conducts a Billing and Services Review to insure that DBH's payment for services are appropriately documented. A Billing and Services Review includes all major programs paid for by the DBH through its general revenue funds. The reviews include a sampling of claims that have been billed and paid. In the event that documentation, clinical, or program compliance related concerns become apparent during the course of the review, the review period of the sample may be expanded, service personnel records may be reviewed, and a comprehensive review of clinical service may be conducted. The Billing and Services Review team also provides technical assistance to sites on appropriate Medicaid documentation of services.

In addition, the DBH Research unit has developed reports to examine average lengths of stay; average cost of levels of care and overall episode of care; utilization of services including community support, residential services, day treatment, trauma services, co-occurring disorder services, family conference, family therapy, individual and group counseling, and academic education. The reports show results by provider and are meant to aid in the monitoring process and to guide technical assistance.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

Consultation with Tribes

The state of Missouri does not have any federally recognized tribal governments or tribal lands within its borders.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Q Data and Information Technology

- **Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;**

The Department of Mental Health's Consumer Information Management Outcomes and Reporting (CIMOR) system provides client-level data.

- **List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;**

In October 2006, the Department of Mental Health (DMH) replaced approximately 15 legacy systems with a web-based information system called Customer Information Management Outcomes and Reporting (CIMOR) system. CIMOR provides for the intake and tracking of consumers – including admission, level changes, and discharge – collection of Treatment Episode Dataset (TEDS) data, state facility bed management, event tracking for incidents impacting consumer safety, clinical screening and assessments, recording of diagnostic information for both DSM-IV and ICD-9 code sets, tracking of court commitments, recording of clinical encounters, authorization request and approval processes, maintenance and tracking of department funding and program expenditures, claims adjunction and payment, voucher management and Government Performance and Reporting Act (GPRA) data collection for the federal Access to Recovery III program, tracking of Medicaid benefit eligibility, consumer banking for management of consumer funds held in trust by state facilities, provider management, standard means test (SMT) application, outcomes reporting, and waiting lists. Encounters do capture type, amount, and cost of service provided, date provided, and location of service delivery. CIMOR captures reimbursable medications for non-Medicaid consumers but not for non-reimbursable medications. For Medicaid consumers, pharmacies direct bill the state Medicaid agency.

Authorized DMH staff have access to CyberAccess, which is an electronic health record for Medicaid consumers. CyberAccess is a web-based, HIPAA compliant portal that enables users to view the complete medical and drug claim history for Medicaid fee-for-service participants. The claim history is extracted from paid claims and goes back approximately two years. CyberAccess allows direct Medicaid consumer lookup. In addition, DMH receives Medicaid claims data in batch bi-monthly, which is loaded onto the data warehouse to support the department's data analytics and reporting activities. Reports are generated from CIMOR data and from Medicaid claims data. Currently, there are no plans to develop electronic health records in CIMOR due, in part, to limited resources.

CIMOR was designed to comply with federal security and privacy requirements. Security in CIMOR is role-based and access to screens and functions is dependent upon one's job duties. CIMOR interfaces with Medicaid eligibility data from the Department of Social Services to determine benefits eligibility and with social security number (SSN) data from the Social Security Administration for SSN verification. As of April 2011, all divisions of the DMH are using CIMOR.

The Division of Behavioral Health (DBH) requires contracted substance abuse treatment providers to obtain national provider identifiers which are maintained in CIMOR. CIMOR also maintains the Inventory of Substance Abuse Treatment Services (I-SATS) identifier assigned to treatment sites for TEDS reporting. In addition, CIMOR assigns all organizations a unique identifier primarily for internal use. All consumers receive a unique identifier that is permanently assigned and maintained by CIMOR and is used by all DMH divisions. CIMOR also collects the Department of Corrections identifier for parolees and probationers, driver's license number for DWI traffic offenders, DCN for Medicaid consumers, and SSN on all ADA consumers.

DBH has contracted with a software firm to develop an end-to-end charting solution for several of the state facilities. ChartAssist provides behavioral health clinicians the tools necessary for meeting the assessment, treatment planning, and treatment scheduling needs unique to hospitals. ChartAssist features also include all components necessary for comprehensive and complex bio-psycho-social assessments. Treatment plans are constructed to facilitate the achievement of a patient's recovery goals, while providing measurable, observable and verifiable metrics to track progress toward those goals. Several of the ChartAssist modules have been implemented at Fulton State Hospital, Hawthorne Children's Psychiatric Hospital, and Northwest Missouri Psychiatric Rehabilitation Center.

- **Provide information regarding its current efforts to assist providers with developing and using EHRs;**

The Division of Behavioral Health (DBH) encourages providers to adopt EHRs during provider director meetings and in other communications.

- **Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and**

Missouri uses an encounter/claims based approach to payment.

- **Identify the specific technical assistance needs the state may have regarding data and information technology.**

None are identified at this time. The primary barrier to implementation of new data requirements and/or information technology is limited resources.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

Quality Improvement Plan

In March 2013, the Divisions of Alcohol and Drug Abuse (ADA) and Comprehensive Psychiatric Services (CPS) combined to form the Division of Behavioral Health (DBH). DBH is in the initial stages of developing a comprehensive Quality Improvement Plan that takes into account the merger of the two divisions. The development process will involve the DBH stakeholders including the Mental Health Coalition and the two State Advisory Councils on Alcohol and Drug Abuse and Comprehensive Psychiatric Services. The timeline for implementation has not yet been established.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

Footnotes:

Missouri Suicide Prevention Plan

A Collaborative Effort

Bringing a National Dialogue to the State

(Revised 2012)

The Personal and Public Tragedy of Suicide

The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.

Kay Redfield Jamison

Suicide is the eleventh leading cause of death for adults and the third leading cause for kids.

There are many more suicides in Missouri than homicides

Every day two people die by suicide in Missouri

INTRODUCTION

Purpose of the Suicide Prevention Plan

"Suicide has stolen lives around the world and across the centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives."[1] "Compounding the tragedy of loss of life, suicide evokes complicated and uncomfortable reactions in most of us. Too often, we blame the victim and stigmatize the surviving family members and friends. These reactions add to the survivors' burden of hurt, intensify their isolation, and shroud suicide in secrecy."[2]

In response to national recognition of suicide as a worldwide public health problem, collaborative planning efforts began in Missouri that resulted in the passage of legislation in 2003 that mandates the development of this statewide suicide prevention plan. The Missouri Suicide Prevention Plan has been developed with broad input from public health experts, mental health providers, suicide survivors and twelve town hall meetings conducted in communities across Missouri (Appendix 1). The recommendations have been developed using reviews of research, experience of other states in suicide prevention and experience gained in suicide prevention efforts in Missouri. Broad community input was sought to tailor the scientific knowledge and national experience to address the specific needs of Missouri communities and organizations.

The planning process united various organizations and brought together partners who each play a role in identifying and solving the problem. This Plan was designed to assist stakeholders in providing services where most needed and where gaps in service exist, thus avoiding duplication and competition by suggesting ways to coordinate activities. This plan was developed to raise awareness of the suicide problem not only among the agencies and groups involved in the planning process, but also among the general population. This plan has been written in such a way as to be applicable to all groups and populations. And lastly, this plan encourages individual communities to develop customized strategies and implement them in a manner that fits their local needs and resources. All Missourians are urged to act on these recommendations to help reduce the preventable tragedy of suicide.

Suicide Prevention Principles for Missouri

This plan seeks to encourage the development of community-based plans and programs that:

- Enhance or strengthen protective factors and reduce the impact of risk factors;
- Promote and address help-seeking behaviors as the norm;
- Are targeted to the level and type of risk of the specific population in Missouri;

[1] National Strategy for Suicide Prevention, p. 17
[2] Surgeon General's Call to Action

- Are developmentally appropriate and culturally sensitive;
- Are focused and adapted to the specific needs of a local area's population; and
- Are sustainable with repeated positive messages, prevention strategies and evaluation.

Definitions and clarifiers are included in the Appendix.

SUICIDE PREVENTION AND THE PUBLIC HEALTH APPROACH

Suicide is a preventable public health problem.

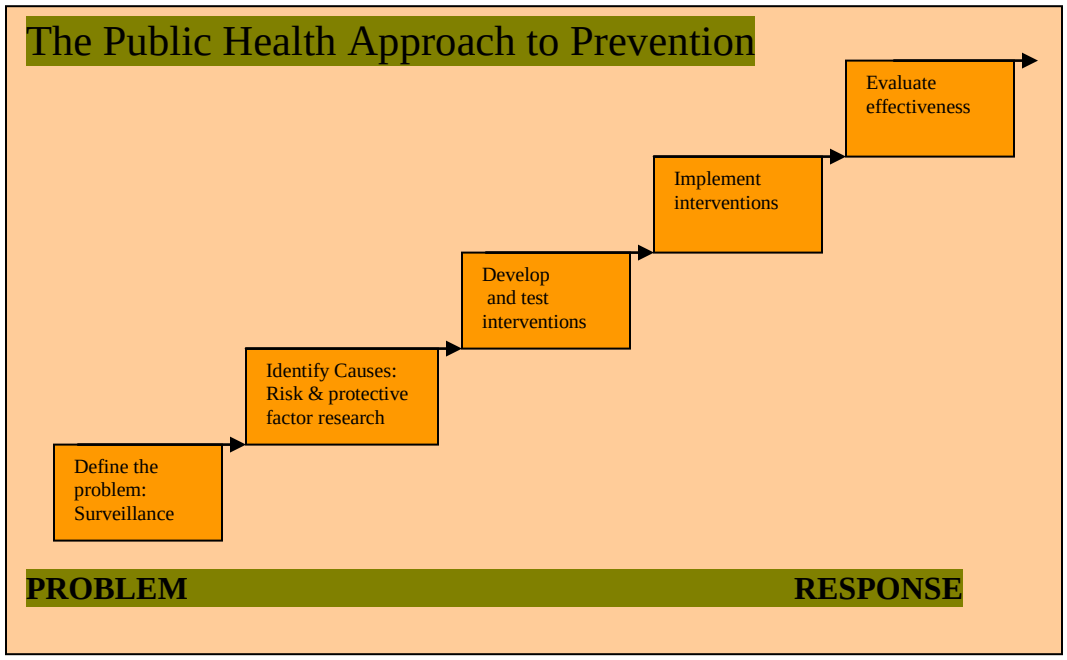
Suicide is a major health problem because of the large number of people impacted and the enormous health care costs associated with it. However, there is a growing body of evidence that indicates that suicide is preventable. A large number of researchers have undertaken the task of understanding the roots of suicide and preventing its occurrence. Suicide can be prevented and its impact reduced in much the same way as public health efforts have prevented and reduced other health problems, such as infectious diseases, pregnancy complications, and injuries.

What can a Public Health Approach Contribute to Suicide Prevention?

The public health approach is a rational and systematic way to marshal prevention efforts and to assure that those efforts are effective. There are several characteristics of the public health approach that makes it the ideal way to address suicide prevention.

In concert with the clinical medical approach, which explores the history and health conditions that could lead to suicide in an individual, the public health approach focuses on identifying patterns of suicide and suicidal behavior within a population group. The public health approach is based on the rigorous requirements of the scientific method, moving from problem to solution. It starts by defining the problem, and then identifies the risk factors, protective factors and causes of the problem. Utilizing that information, interventions are developed, implemented and evaluated for effectiveness.

The public health approach to any problem is interdisciplinary and draws upon the knowledge of many disciplines. This broad knowledge base allows the field of public health to be innovative and responsive to the many different underlying issues thought to be associated with suicide and suicidal behavior. The public health approach emphasizes collective action and cooperative efforts among diverse agencies such as health, mental heath, social services, education, law enforcement and corrections. The public health approach requires individuals, communities, organizations and leaders at all levels to collaborate in promoting suicide prevention.



Although the diagram above suggests a linear progression from the first step to the last, in reality the steps often overlap and depend upon each other. In fact, the evaluation of effectiveness itself leads to a redefining of the problem and additional surveillance. The public health approach is a cycle. The next three sections of this report will address the specific steps of the public health model.

DEFINING THE PROBLEM OF SUICIDE

Suicide exacts an enormous toll from the American people.

- Suicide claims more than 38,364 American lives (2010).
- Suicide ranks as the 10th leading cause of death in the U.S.
- The rate of suicide is 12.4 per 100,000 equaling almost 1.5% of all deaths.
- An average of 1 person kills themselves every 13.7 minutes.
- For each completed suicide, as many as 25 people may make a non-lethal attempt.

Suicide affects everyone, but some populations have higher numbers.

- Suicide is the 3rd leading cause of death for youth age 15 – 24.
    - 15.8% of students have 'seriously considered' attempting suicide in the last 12 months.
    - 7.8% have made a suicide attempt in the last 12 months.
- Older adults (age 65 and over) account for 15.6% of completed suicides.
    - For those over the age of 65, there is 1 suicide for every 4 attempts.
    - About 60% of elderly patients who take their own lives have seen their primary care physician within a few months of their death.

More Missourians die by suicide than by DWI, homicide, or AIDS.

- Missouri's rate of suicide is 14.3 / 100,000, which is the highest in Region VII (Kansas, Iowa, Nebraska and Missouri).
- Suicide is the 10th leading cause of death in Missouri.
- An average of 842 Missourians die by suicide annually (over the period 2007-2011).
- The leading methods of suicide in Missouri are: firearms (56%), suffocation (21%), and poisoning (18%)
- Men account for 79% of completed suicides; women 21%
- 93.6% of deaths by suicide are white non-Hispanics; while 5.1% are black/African-American

Note: National data are from the American Association of Suicidology, U.S.A. Suicide: 2010 Official Final Data, www.suicidology.org.

Missouri data are from the Missouri Department of Health and Senior Services, Death MICA Statistics, http://health.mo.gov/data/mica/mica/death.php.

RISK FACTORS AND PROTECTIVE FACTORS

The public health approach to suicide prevention often is based on decreasing risk factors associated with suicidal behavior and enhancing the protective factors. Understanding the interactive relationship between risk and protective factors in suicidal behavior continues to be studied and drives the development of interventions.

Risk Factors

Risk factors are a combination of stressful events, situations, and/or conditions that may increase the likelihood of suicide, especially when several coincide at any given time.
Risk factors for suicide include but are not limited to[3]:

Biopsychosocial Risk Factors:

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders;
- Alcohol and other substance use disorders;
- Hopelessness;
- Impulsive and/or aggressive tendencies;
- History of trauma or abuse (bullying, violence and assault);
- Some major physical illnesses;
- Previous suicide attempt; and
- Family history of suicide.

Environmental Risk Factors:

- Job or financial loss;
- Relational or social loss (divorce, incarceration, legal problems);
- Easy access to lethal means; and
- Local clusters of suicide that have a contagious influence.

Sociocultural Risk Factors:

- Lack of social support and sense of isolation;
- Stigma associated with help-seeking behavior;
- Barriers to accessing health care, especially mental health and substance abuse treatment;
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma); and
- Exposure to suicidal behavior of others, including through media coverage and influence of others who have died by suicide

Protective Factors

Protective factors make it less likely that individuals will develop suicidal ideations; and may encompass biological, psychological or social factors in the individual, family and environment.
Protective factors include: [4]

- Effective clinical care for mental, physical, and substance use disorders;

[3] National Suicide Prevention Strategy
[4] National Suicide Prevention Strategy

- Easy access to a variety of clinical interventions and support for help-seeking;
- Restricted access to highly lethal means of suicide;
- Strong connections to family and community support;
- Support through ongoing medical and mental health care relationships;
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes; and
- Cultural and religious beliefs that discourage suicide and support self-preservation.

INTERVENTIONS: DEVELOPMENT, IMPLEMENTATION AND EVALUATION

The first two steps of the public health model provide important information about populations impacted by suicide. Developing that knowledge into effective interventions is a central goal of public health. Researchers in the field of suicide prevention are focusing efforts on specific groups. Interventions are grouped as follows:

Universal Interventions aimed at the general population without regard to individual risk.

Selected interventions aimed at those considered at heightened risk for suicide (having one or more risk factors).

Indicated Interventions aimed at specific individuals that have a risk factor or condition that puts them at extreme high risk.

Many suicide interventions have been developed and are being implemented; most continue to be evaluated to determine their effectiveness. Some of the more common interventions include clinical treatment, behavioral and relationship approaches, community-based efforts such as suicide and crisis prevention centers, school-based interventions, restricting access to means, gatekeeper training, improved access to care, awareness campaigns, media reporting and interventions with survivors.

The development, implementation and evaluation of effective interventions in Missouri is a major goal of this plan. The plan is intended to provide broad guidelines from which communities can base local planning and implementation efforts.

Recommendation

Communities should use this plan as a guide to the development and implementation of their own local plans. Through strong community action, the overall goal of this plan for suicide prevention is to reduce suicide and suicidal behaviors in all populations. Missouri has followed the AIM framework (Awareness, Intervention, Methodology) as stated in the Surgeon General's Call to Action with recommendations for initiatives in each of the three areas, awareness, interventions, and methodology.

Suicide is a huge, complex problem and Missouri's communities are too diverse in their members and needs for a single intervention to be adequate. Thus, a diverse array of interventions will be required to meet the particular local needs of the many unique communities in Missouri. Collaboration is essential if the activities outlined in this section are to be effective. The following are key to the success of this plan:

- Suicide prevention is everybody's responsibility. Every Missourian should effectively promote prevention efforts, whether at the individual, community or agency level.

- Additional federal, state and local funding should be pursued to increase access to mental health and substance abuse treatment and suicide prevention efforts.

Focus 1 - Awareness

In Missouri, the suicide prevention messages should be consistent among all those engaged with awareness efforts. That message should include information regarding:

- Risk and protective factors,
- Stigma reduction by increasing the acceptability of asking for help around mental health issues,
- The importance of screening and early interventions,
- The effectiveness of treatments currently available for mental illness and substance abuse disorders,
- Where to go for help. (See resource list.)

Action 1: Develop public awareness initiatives designed to change attitudes toward accessing care, the acceptability of seeking help and the availability of treatment.

- Develop public service announcements, brochures, resource guides; billboards, videos, Internet Web sites, and a speaker's bureau.
- Identify community partnerships and collaborations to distribute information.
- Identify funds and resources to assist in local implementation of awareness efforts.
- Promote the use of national and state suicide prevention hotline numbers.

- Develop strategies to target specific groups to receive information from the public awareness initiative. These groups will include but not be limited to the following:
    - Journalists, including print and broadcast media;
    - School boards, administrators, staff, and students;
    - Social services, health, mental health and criminal justice professionals;
    - Public officials, libraries, clergy;
    - Consumers, survivors and families; and
    - Employer associations, unions and safety councils.
- Promote inclusion of suicide prevention as part of conferences and training that pertain to high risk populations.

Action 2: Promote activities to further investigate and implement ways to influence positive attitudes and behaviors (to seek help and to access appropriate treatment).

Action 3: Develop training and education opportunities for providers of services to high-risk populations; including but not limited to:

- Education professionals:
- Case managers;
- Criminal justice professionals;
- Older adult service agencies, including Area Agencies on Aging (AAAs)
- Child and adolescent program providers;
- Social services, health, and mental health professionals;
- Employee assistance programs; and
- Suicide prevention training experience should be included in:
    - Basic professional development courses,
    - Continuing education courses and workshops,
    - Conferences and training sessions,
    - Existing community based forums attended by the above groups.

Action 4**:** Ensure that the suicide prevention message is consistent across agencies and that the prevention strategies and information about the risk and protective factors are integrated into suicide-related materials of all groups and agencies.

- Monitor the development of suicide prevention messages and assure that they are guided by the state plan.

Focus 2 - Interventions

Improve access and availability of services that encourage early detection, promote intervention and eliminate stigma associated with suicidal ideation/behavior.

Action 5: Endorse, recommend and/or develop appropriate screening tools.

- Assessment of coping and problem solving skills and help seeking behaviors;
- Promote informal mental health screenings (anxiety, depression, stress, etc);
- Encourage inclusion of formal mental health screenings to the medical community; and
- Assure use of age appropriate tools for early identification of suicidal ideation across the lifespan.

Action 6: Promote the development of prevention and intervention training within communities for all citizens.

- Develop community education opportunities;
- Recommend gatekeeper training curricula;
- Include suicide prevention and intervention training for those working in elementary and secondary education and institutions of higher learning;
- Identify key members of the community, both professional and lay persons;
- Target providers of services to high-risk populations; including but not limited to:
    - Education,
    - Case managers,
    - Criminal justice professionals,
    - Older adult service agencies, including Area Agencies on Aging,
    - Child & adolescent program providers,
    - Social services, health and mental health professionals,
    - Employee assistance programs, and
    - Churches, synagogues, mosques
- Suicide prevention training component(s) should be included in:
    - Professional curricula development,
    - Continuing education and refresher opportunities,
    - Conferences and related enrichment, and
    - Community based forums.

Action 7: Publicize community, state and national crisis telephone hotlines.

- Develop community rosters of available telephone services; and
- Assist providers of telephone services in marketing of services

Action 8: Develop community-based interventions/action plans that support participation of minority and non-traditional populations (caregivers, 1st responders, etc.).

- Support the development of community-based forums to address suicide;
- Involve local communities and support local efforts to prevent suicide by assessing and acting on local risk or protective factors;
- Provide or assist in obtaining funding for prevention initiatives sponsored by local efforts; and
- Facilitate formation of new suicide survivor support groups

Action 9: Promote and encourage the use of existing local prevention and intervention resources including but not limited to:

- Mental health service providers;
- Community service providers;
- Opportunities to facilitate community networking; and
- Development of a community resource guide; provided via access to a data base or website.

Action 10: Encourage collaboration among law enforcement, mental health and other service providers.

- Implement crisis intervention teams; and
- Cross train staff for greater understanding of situation management and to impact a positive end result

Action 11: Improve capacity for primary care providers to refer patients for appropriate care.

- Strive for mental health and substance abuse treatment insurance parity; and
- Identify and reduce barriers to adequate care (transportation, provider availability, facility location, financial, work-related, etc.).

Action 12: Promote the use of follow-up protocols and supports.

- Identify and provide protective services after suicide risk has been identified (support groups, skill building/educational programs, self-enhancement activities);
- Eliminate barriers in public and private insurance programs for provision of mental health treatments;
- Develop and implement effective training and support programs for family members of those at risk; and
- Identify protocols for aftercare for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a proportion of these settings.

Focus 3—Methodology

Action 13: Develop methods to assess the occurrence of suicide attempts and suicide completions in Missouri.

- Improve reporting and the accurate surveillance of suicide and suicidal behaviors.

Action 14: Promote the development of scientific knowledge in suicide prevention activities within the state and the establishment of research partnerships.

- Review suicide prevention projects for their potential to add to evidence-based prevention knowledge and their effectiveness in diverse settings and among different age, gender and ethnic subgroups; and
- Foster partnerships to conduct scientific research and secure external funding.

Action 15: Assess the cultural, gender, and age attitudes toward getting help for depression and suicide, as well as the barriers (stigma) related to refusing help, and the attitudes of Missourians about clinical interventions for mood disorders (psychotropic medication and psychotherapy).

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APPENDIXES

1. TOWN HALL MEETING
2. HISTORY OF THE MISSOURI PLANNING PROCESS
3. EVIDENCE BASE FOR SUICIDE PREVENTION
4. RESOURCES
5. GLOSSARY

APPENDIX I

Report

on the

Town Hall Meetings

for the

Missouri Suicide Prevention Plan

A Collaborative Effort

Go to the people
Work with them
Learn from them
Respect them
Start with what they know
Build with what they have

And when the work is done
The task accomplished
The people will say,
“we have done this ourselves”
-Lao Tsu, China 700 BC

Introduction

Town Hall Meetings were held through out the state during July, August and September of 2004 to receive public input on the draft suicide prevention plan in preparation for submission to the state legislature by December 31, 2004 as mandated by legislation passed in 2003. The plan is titled "Missouri Suicide Prevention Plan: A Collaborative Effort". This report is divided into two sections, one that describes the process used and the other describes the input received.

Process

A "Call to Host" was sent to mental health, health, corrections, education, and community-based organizations in April and May. Approximately twenty-three agencies and organizations responded to the call to host the town hall meetings. Many of who resided in the same cities or in close proximity to each other, thus some agencies agreed to share the responsibility of hosting town hall meetings. Host agency responsibilities included:

- Providing adequate space to hold a three to four hour meeting that is accessible to the community.
- Assisting in the general advertisement and promotion of the town hall meeting and to notify and involve key community leaders.
- Providing light refreshments (coffee or water) – optional.

The Town Hall Meetings were held in fourteen communities and generally lasted for approximately 2 hours. Approximately 535 individuals were in attendance. Participants included consumers, survivors and community representatives from health, mental health, alcohol and drug abuse, corrections, police, funeral directors, and educational agencies. The plan was made available prior to the meetings and attendees were encouraged to read the plan prior to the meeting.

The meetings consisted of a Power Point presentation describing the development and contents of the plan, an open mike session, and breakout groups. Participants were asked to respond to the plan by answering the following questions:

1. What did you like about the plan and why?
2. What did you like least about the plan and why?
3. What has not been included, but should be?
4. What can be done to make it more likely that people will act on recommendations and become involved in suicide prevention activities?

Participants were given three methods to provide general feedback and to respond to these four questions:

1. Attendees were given an opportunity to provide verbal feedback during the meeting during the open mike session and during the group breakout sessions.
2. Feedback cards that listed the four questions were distributed to each attendee. They were asked to provide written feedback and to submit the cards at the end of the meeting.
3. Attendees were given a dedicated e-mail to send additional comments after the meeting.

Input

Surveys of the attendees during the meetings revealed that 80 to 90% of the attendees had not read the plan prior to the meeting. A summary of responses from the fourteen meetings to each of the four questions are listed below.

1. What did you like about the plan and why?

All attendees recognized the importance of suicide prevention and expressed the need for collaborative action. Attendees favorably responded to the use of the National Suicide Prevention Strategies, the Surgeon General's Call to Action and the Public Health Approach as models for the state plan.

Other components of the plan that received recurring positive comments included: use of local community resources, awareness and prevention education, early identification of risk factors, evidence based practices, stigma reducing strategies, and attention to survivors' issues. Comments reflected the plan was comprehensive, broad based, well organized and easy to read.

2. What did you like least about the plan and why?

In summarizing the written comments received for this question, it became more evident that many of the attendees were not familiar with the plan and that the questions were misinterpreted. For example many comments listed were more accurately in response to question number 3.

Many of the comments under this question reflect a desire for more information and education on specific risk factors and at risk groups (for example violence and abuse and specific age categories). The items participants liked least about the plan is that it did not include how the plan was to be funded.

3. What has not been included but should be?

Funding was the major point identified as missing from the plan; how to access money, sustain programming and fund efforts seemed to be the primary roadblock. Interventions for specific populations (G/L/B/T, Hispanic, rural, youth/elderly, etc.) identification of and access to resources (telephone hotline numbers, crisis services, and counseling services), improved skill building programs (coping, awareness, teacher education, etc.) identification of reference materials, websites, and training curricula were frequently cited. The lack of psychiatric

inpatient beds and after hours crisis options were frequently mentioned.

4. What can be done to make it more likely that people will act on recommendations and become involved in suicide prevention activities?

Creating media advertising and community based awareness campaigns were identified as the leading way to get people involved. Enhancing public education, creating greater awareness and making training opportunities more readily available were recommended. Identifying 'systems of care' within communities, options and availability for help, and how to become a 'helper' were recommendations as well. Collaborative efforts that advance advocacy, reduce stigma and encourage greater community involvement were also suggested.

Conclusion

The Town Hall meeting process allowed for considerable input from consumers, survivors and providers at the local level. The plan was generally well received and community input was productive. Town Hall audiences were supportive of the plan and expressed hope that it would be implemented. Many criticisms of the plan resulted from not having read the draft prior to the meeting: other critiques were useful to the writing team and they worked to finalize the draft plan.

APPENDIX II

ACTING ON SUICIDE PREVENTION
MISSOURI'S ROLE IN A NATIONAL MOVEMENT

A. Call to Action

In 1998 the U.S. Surgeon General, David Satcher, identified suicide as a major public health problem. He convened more than 450 leading public health officials, mental health professionals and consumer advocates from all over the country to begin the process of addressing suicide as a significant health problem. This resulted in *The Surgeon General's Call to Action to Prevent Suicide (1999)* where Dr. Satcher established the promise that

> "We must promote public awareness that suicides are preventable. We must enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment. And we must reduce the stigma associated with mental illness that keeps many people from seeking help that could save their lives."

The Surgeon General's Call to Action to Prevent Suicide presented the nation with an initial blueprint for addressing suicide AIM

- Awareness,
- Intervention
- Methodology

AIM provided both the framework for immediate implementation of suicide prevention initiatives and also served as the foundation for development of the more comprehensive *National Strategy for Suicide Prevention.*

B. National Strategy for Suicide Prevention

In 2001 the U.S. Department of Health and Human Services, through the Surgeon General's Office issued the *National Strategy for Suicide Prevention.* The strategy identifies suicides high cost to the American nation noting that as the eighth leading cause of death in Americans, suicide kills 50% more people than homicide and twice as many people as HIV/Aids. The goal of the strategy is to provide national guidance to prevent suicide and reduce the rates of suicidal behaviors, reduce the traumatic after effects that suicide has on family and friends and to enhance the resiliency and interconnectedness of individuals and their communities. The national goals are:

1. Promote awareness that suicide is a public health problem that is preventable.
2. Develop broad-based support for suicide prevention
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services
4. Develop and implement suicide prevention programs

5. Promote efforts to reduce access to lethal means and methods of self-harm
6. Implement training for recognition of at-risk behavior and delivery of effective treatment
7. Develop and promote effective clinical and professional practices
8. Improve access to and community linkages with mental health and substance abuse services.
9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media
10. Promote and support research on suicide and suicide prevention
11. Improve and expand surveillance systems

C. The *Missouri Suicide Prevention Plan 2001-2003*.

The initial *Missouri Suicide Prevention Plan 2001-2003* was developed in a collaborative process headed by then Missouri Department of Health and Missouri Department of Mental Health using a series of regional and statewide planning meetings that also included Department of Elementary and Secondary Education, Department of Corrections, community self-help groups and survivors. This plan using the AIM format led to actions including:

1. Public awareness campaigns using radio, TV and billboards.
2. Suicide prevention training for professional caregivers including public health nurses, school counselors, gambling counselors, substance abuse counselors, probation and parole officers and others
3. Training of hundreds of Suicide Prevention Gatekeepers (gatekeepers are anyone who by virtue of their daily activity come into contact with individuals who may be at risk for suicide and can recognize and refer for help).
4. Community based efforts.

D. The Missouri Legislature takes Action

In Fall of 2003 the 92nd General Assembly passed the bipartisan House Bill #'s 59 and 269 directing the Director of the Department of Mental Health in partnership with the Department of Health and Senior Services in collaboration with other agencies and community organizations to develop a new state suicide prevention plan including but not limited to workplaces, schools and public and community health settings. The plan was submitted to the general assembly in 2004.

Appendix III
Evidence Base for Suicide Prevention

Strategy	Rationale	Limitations	Effect
School-based Suicide Awareness Curriculum	Some research available on teenager's attitudes on help seeking behavior	▪ Some shifts in desirable attitudes ▪ some evidence of increase in maladaptive coping ▪ Possibility of contagion.	Minor increase in knowledge and attitude shifts.
Screening	Extensive research on risk factors available from psychological autopsy studies and studies of attempters	▪ Many false positives identified ▪.Assistance in referrals to adequate treatment necessary.	If targets of screening depression, substance abuse and suicide attempts are treated the potential impact on reducing suicides is considerable.
Gatekeeper Training	Similar to CPR Trains members of general public to identify persons at risk, briefly intervene then refer person to professional	Repetition of training program appears necessary	Evidence of knowledge gain and reduction of gender specific suicidal rates
Crisis Centers and Hotlines	Psychological autopsy studies indicate that suicide is often associated with a stress event	Widely available but less apt to be used by boys	Decrease of over 1/3 in suicide rate for young white females
Restriction of lethal means	Several studies indicate availability of firearms in homes significantly increases risk of completed suicide	Second Amendment rights limit acceptability within segments of public	23% reduction in firearm suicides reported. Method substitution appears to be minimal.
Media Education	Numerous studies indicate existence of suicide contagion	Media might be reluctant to participate. Turn over of editorial staff and journalists would require repetition of education programs.	7% reduction in suicides reported in first year and 20% over 4 years post guidelines.
Postvention/crisis intervention	Several studies have examined	High risk persons are not necessarily identified without systematic screening	Not yet known.

Appendix IV

RESOURCES

I Federal Policy and Plans

National Action Alliance for Suicide Prevention
http://actionallianceforsuicideprevention.org/

National Strategy for Suicide Prevention (2012)
www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/

Surgeon General's Call to Action to Prevent Suicide (1999)
http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBBH

II State and National Resources

American Association of Suicidology
www.suicidology.org

Best Practices Registry
www.sprc.org/bpr

Missouri Department of Health and Senior Services
http://health.mo.gov/

Missouri Department of Mental Health
http://dmh.mo.gov/crisis.htm

National Institute of Mental Health
www.nimh.nih.gov/health/topics/suicide-prevention/

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org

Suicide Prevention Resource Center
www.sprc.org

III Missouri Data on Deaths, Hospitalization and ER Visits

Missouri Information for Community Assessment (MICA)
http://health.mo.gov/data/mica/MICA/

Appendix V

Glossary
for Missouri State Suicide Prevention Plan

attempter: *an individual who makes a nonfatal suicide attempt. An attempter carries out a suicide plan but does not die as a result of their action(s)*

awareness: *broaden the public's recognition, knowledge and understanding*

best practice: *an activity or program based on the best available evidence regarding what is effective*

biopsychosocial: *biological, psychological and social elements that may influence behavior(s) (mental disorder, substance use/abuse, history, etc.)*

cause: *contributing factor or condition*

completer: *a person who intentionally caused their own death*

comprehensive suicide prevention plans: *plans that use a multi-faceted approach to addressing the problem; for example, including interventions targeting , biological, psychological and social factors*

connectedness: *closeness to an individual, group or people within a specific orgnaization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others*

contagion: a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

culturally appropriate: *a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles,*

depression: *a collection of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack or pleasure*

environmental: *physical or social elements that influence behaviors (financial, home, relationships, etc.)*

gatekeeper: *those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as needed*

goal: *a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work*

intervention: *a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition*

lethality: *the potential for death*

means: *the insturment or object whereby a self-destructive act is carried out*

means restriction: *techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm*

methodology: *advance the scientific research, evaluation, and monitoring systems for the prevention of suicide and suicidal behaviors*

method: *action or technique which results in an individual inflicting self-harm*

non-lethal: *non-fatal, injury may occur*

objective: *a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often*

outcome: *a measurable change in the health of an individual or group of people that is attributable to an intervention*

postvention: *a strategy or approach that is implemented after a crisis or traumatic event has occurred (this can also be a form of prevention for future attempts).*

prevention: *a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors*

protective factors: *factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment*

risk factors: *those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment*

screening tools: *those instruments and techniques used to evaluate individuals for increased risk of certain health problems; examples, questionnaires, check lists, self-assessment forms, etc.*

sociocultural: *consideration of the influences of societal &/or cultural norms, beliefs and attitudes*

stakeholders: *entities, including organizations, groups and individuals, that are affected by and contribute to decisions, consultations, and policies*

stigma: *an object, idea, or label associated with shame, disgrace, dishonor or reproach*

suicidal behavior: *a variety of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide*

suicide: *death where there is evidence that a self-inflicted act led to the person's death*

surveillance: *the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings*

survivor: *family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide*

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

T Use of Technology

- **What strategies the state has deployed to support recovery in ways that leverage ICT;**

The Division of Behavioral Health (DBH) funds telehealth services including assessment, individual counseling, and medication services.

- **What specific application of ICTs the State BG Plans to promote over the next two years;**

The Division of Behavioral Health (DBH) plans to continue funding telehealth services assessment, individual counseling, and medication services.

- **What incentives the state is planning to put in place to encourage their use;**

Programs recognize the potential cost effectiveness and clinical benefits in using this technology as many providers operate in rural areas. The use of this technology decreases overhead costs, improves access, and makes better use of clinician time.

- **What support system the State BG Plans to provide to encourage their use;**

The Division of Behavioral Health provides technical assistance and review of plans for the delivery of telehealth services.

- **Whether there are barriers to implementing these strategies and how the State BG Plans to address them;**

The DBH would like to have services, besides medication services, delivered via telehealth to be covered by Medicaid. However, such requests have not been approved by the Medicaid agency in Missouri for significant reasons. Thus, the use of non-Medicaid funds for services delivered via telehealth is crucial.

- **How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;**

The DBH has long been strongly encouraging behavioral health providers to reach out to community stakeholders and providers of primary care services, developing collaborative relationships wherever possible. The DBH works closely with the Missouri Primary Care Association in terms of high-level coordination of behavioral and physical health services. The use of technology has not yet specifically been a focus of collaborative efforts.

- **How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and**

The State will continue to collect program data via its information system. Billing of telehealth services are identified by a unique procedure code.

- **What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.**

No measures specific to ICT have been identified at this time.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

U Technical Assistance Needs

1. What areas of technical assistance is the state currently receiving?

The Missouri Division of Behavioral Health is not currently receiving technical assistance.

2. What are the sources of technical assistance?

The Missouri Division of Behavioral Health (DBH) is not currently receiving technical assistance. In the past, DBH has received technical assistance from SAMHSA and from the Southwest Center for the Application of Prevention Technologies (SWCAPT).

3. What technical assistance is most needed by state staff?

None is identified at this time.

4. What technical assistance is most needed by behavioral health providers?

For prevention providers, ongoing training on data-informed decision making is needed.

For treatment providers, additional technical assistance is needed in the following areas:

- Integration of substance use disorder services with primary care,
- Developing trauma sensitive organizations and delivering trauma-informed behavioral health services,
- Marketing in the new healthcare environment, and
- Effective case management and care coordination of individuals with substance use disorders.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.[45] This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

V Support of State Partners

The Missouri Department of Mental Health (DMH) has strategic partnerships with its sister agencies including the Department of Social Services, the Department of Health and Senior Services, the Department of Elementary and Secondary Education, the Department of Corrections, the Department of Public Safety, the Office of State Court Administrators, and the Department of Insurance, and the Office of Administration. DMH has had formal written memorandums of understanding (MOU) with many of these agencies.

Department of Corrections

DMH and the Department of Corrections (DOC) maintain an MOU to coordinate monitoring and review of community-based addiction programs that serve offenders under community supervision. The agreement provides for the transfer of DOC substance abuse community services funding to DMH. DMH is required to monitor appropriation balances to assure funds are expended appropriately and provide DOC with quarterly reports on utilization of contract funds. The agreement also requires DMH and DOC to establish a process for referring offenders to treatment.

DMH and DOC maintain an MOU to efficiently provide, through existing community service contracts, comprehensive psychiatric services for DOC supervised offenders who have moderate to serious mental health conditions. Joint responsibilities include:

- Work together to provide input for contract amendments;
- Provide monitoring and technical assistance activities of community providers/contractors; and,
- Participate in oversight committee, which will include the designated management staff of contractor, P&P Contract Manager, and DMH staff members.

DMH and DOC maintain an MOU for collaboration and planning between the Departments should any disaster or emergency occur.

Department of Health and Senior Services

DMH and the Department of Health and Senior Services (DHSS) maintain an MOU to formalize the cooperative process for utilizing a statewide toll free phone number to receive reports of adult abuse and neglect, enhancing DHSS background checks by allowing DHSS access to certain investigated report information and the DMH Employment Disqualification Registry, and further sharing of information to assist each agency in fulfilling its statutory responsibilities.

DMH and DHSS maintain an MOU in coordinating the use of state resources to advance the work outlined in Missouri's Early Childhood State Plan. This agreement is in support of DMH's Project LAUNCH Grant.

Department of Public Safety

DMH maintains an MOU with the Department of Public Safety (DPS) for the enforcement of the federal Family Smoking Prevention and Tobacco Control Act. DMH has loaned DPS four full-time equivalent positions for the sole purpose of enforcing federal and state tobacco regulations to include federal advertising and labeling inspections and state and federal undercover buy inspections. This activity is in support of DMH's Synar program.

Department of Social Services

DBH works closely with three divisions of the Department of Social Services: Children's Division (child welfare); Division of Youth Services (youth adjudicated as delinquent and committed to state custody); and MO HealthNet (Medicaid agency).

DMH maintains an MOU with the Department of Social Services (DSS), Family Support Division for the referral and provision of substance abuse treatment services for identified applicants and recipients of Temporary Assistance (TA clients) who request referral to an appropriate substance abuse treatment program in lieu of a drug test or who test positive for the illegal use of a controlled substance under the provisions of section 208.027 RSMo.

DMH maintains an MOU with the DSS-Children's Division for voluntary placement so that parents do not have to give up custody of their child to get mental health services.

DMH maintains an MOU with the DSS-Children's Division for inpatient diversion for the provision of intensive programming that diverts the child from being placed in an inpatient setting.

DMH maintains an MOU with DSS-Division of Youth Services to hold slots at DMH's Cottonwood Residential facility for several DSS youth.

DMH maintains a Cooperative Agreement with DSS relating to the Medicaid State Plan for Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) Program. This agreement covers the determination of Medicaid eligibility, Medicaid provider and Department/Division audit and compliance initiatives, and implementation and administration of the CSTAR program.

DMH maintains a Cooperative Agreement with DSS relating to the Medicaid State Plan for Community Psychiatric Rehabilitation (CPR) Program. This agreement covers the determination of Medicaid eligibility, Medicaid provider and Department/Division audit and compliance initiatives, and implementation and administration of the CPR program.

DMH maintains a Cooperative Agreement with DSS relating to the Medicaid State Plan for Targeted Case Management (TCM) for Severely Emotionally Disturbed Children and TCM for Chronically Mentally Ill Adults. This agreement covers the determination of Medicaid eligibility, Medicaid provider and Department/Division audit and compliance initiatives, and implementation and administration of the TCM program.

Missouri Institute of Mental Health

DMH maintains an MOU with the Missouri Institute of Mental Health (MIMH), The Curators of the University of Missouri for the provision of Mental Health First Aid in Missouri (MHFA-MO). DMH's responsibilities include providing a Project Director and Project Manager to support the program; representing Missouri on the MHFA-USA Executive Committee. MIMH's responsibilities include training instructors, providing technical assistance, conducting courses, conducting instructor reviews, and providing CEUs.

In addition, to the formal agreements DMH collaborates with other state agencies on various initiatives and workgroups including the following:

- Council for Adolescent School Health;
- Missouri Coordinated School Health Coalition;
- Stakeholders Advisory Group;
- Child and Family Services Review Advisory Committee;
- Children's Division Recruitment and Retention Workgroup;
- Missouri Alliance for Drug Endangered Children;
- Juvenile Crime Enforcement Coalition for Missouri School Violence Hotline;
- Task Force on the Prevention of Sexual Abuse of Children;
- Comprehensive System Management Team (for state agencies providing services to children);
- Missouri HIV/STD Prevention Community Planning Group;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Children in Nature Committee (to increase education about nature and positive experiences with the outdoors);
- Missouri Behavioral Health Epidemiology Workgroup;
- Show Me Response (disaster & emergency coordination);
- Missouri Reentry Process Steering Team;
- MO HealthNet (Medicaid) Managed Care Quality Assurance & Improvement Advisory Group;
- Mo HealthNet (Medicaid) Behavioral Health Committee for Health Care Reform
- Missouri Alliance to Curb Problem Gambling;
- Midwest Consortium on Problem Gambling and Substance Abuse Committee;
- Mental Health and Aging Workgroup;
- Governor's Committee to End Homelessness;
- Smoking Cessation Planning Workgroup;
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Missouri Drug Court Coordinating Commission;
- Governor's Faith-based and Community Service Partnership for Disaster Recovery;
- Maternal, Infant and Early Childhood Home Visiting Program State Steering Committee;
- Missouri Prevention Partners Coalition; and the
- Mental Health First Aid Advisory Council.

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

State Behavioral Health Advisory Council

1. What planning mechanism does the state use to plan and implement substance abuse services?

Missouri's planning council for alcohol and drug (ADA) programs is comprised of 25 members including service providers, consumers (recipients of services or family members of recipients), and other interested citizens. At least one-half of the members shall be consumers, and one member shall represent veterans and military affairs. No more than one-fourth of the members shall be vendors or members of boards of directors, employees or officers of vendors, or spouses of any of the above mentioned, if such vendors received more than fifteen hundred dollars ($1,500) per year under contract with the Department of Mental Health. Members of boards of directors of not-for-profit corporations shall not be considered vendors. Each member shall be appointed for an initial term of one, two, or three years to allow for a rotation of one-third of the members each year. Further, each appointed member may be re-appointed to no more than one additional three-year term. Each member serves until a successor has been appointed. The functions and duties of the planning council for ADA shall be to:

1) Promote meetings and programs for the discussion of reducing the debilitating effects of alcohol or drug abuse and disseminate information in cooperation with any other department, agency or entity on the prevention, evaluation, care, treatment and rehabilitation for persons affected by alcohol or drug abuse;
2) Study and review current prevention, evaluation, care, treatment and rehabilitation technologies and recommend appropriate preparation, training, retraining and distribution of manpower and its resources in the provision of services to persons affected by alcohol or drug abuse through private and public residential facilities, day programs and other specialized services;
3) Recommend what specific methods, means and procedures should be adopted to improve and upgrade the alcohol and drug abuse service delivery system for citizens of this state;
4) Participate in developing and disseminating criteria and standards to qualify alcohol and drug abuse residential facilities, day programs and other specialized services in this state for funding by the department (RSMO 631.020).

Most members of the ADA planning council have leadership roles as managers, advocates or volunteers in the substance abuse service delivery system. Current representation includes consumers; treatment, recovery support, and prevention service providers; the National Guard; Department of Corrections; Department of Health and Senior Services; the Drug Court Commission; and the Veteran's Administration.

2. How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?

The Division of Behavioral Health (DBH), formerly the Divisions of Alcohol and Drug Abuse (ADA) and Comprehensive Psychiatric Services (CPS), is both the State Mental Health Authority and the State Substance Abuse Authority. The planning council for ADA and the planning council for CPS are separate entities. The State Advisory Council for Alcohol and

Drug Abuse (SAC-ADA) advises DBH on its service delivery system for substance abuse prevention and treatment services. Treatment and prevention subcommittees of the SAC-ADA have active roles in providing information, resources, and recommendations. The prevention subcommittee also has the role of policy development for the Partnership for Success Grant which, for Missouri, focuses on underage drinking and prescription drug misuse.

The State Advisory Council for Comprehensive Psychiatric Services (SAC-CPS) is comprised of 25 members who advise and make recommendations to improve the system of care in mental health. The SAC-CPS membership is required by federal law to have a majority of mental health consumers, including parents of children receiving services and family members. In addition, representation is required from the following state agencies: Social Services, Medicaid, Corrections, Vocational Rehabilitation, Education, Housing and Mental Health. The remainder of the SAC-CPS is made up of private and state-contracted providers, Missouri Protection and Advocacy, and other advocacy groups. The SAC-CPS has the following duties:

1) Review State plans and submit any recommended modifications to DBH;
2) Serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems;
3) Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

The SAC-ADA and SAC-CPS meet in joint sessions as needed to coordinate recommendations on behavioral health services, including recommendations for Missouri's FY 2014-2015 Behavioral Health Assessment and Plan.

Both Councils receive regular briefings from DBH on budget updates, grant programs, legislative updates, DBH initiatives/collaborations, and emerging issues. The DBH Director and/or his representative are in attendance to respond to questions and to solicit recommendations. In addition, DBH section heads provide updates. SAC-ADA also receives briefings from the Missouri Substance Abuse Professional Credentialing Board and the Missouri Recovery Network. The SAC-CPS receives regular reports from its subcommittees on Data, Mental Health Education, and Consumer Conference*/Real Voices, Real Choices*. During FY 2013, SAC-ADA and/or the SAC-CPS have had presentations and in-depth discussions on the following projects:

- Disabilities 101 Website,
- Substance Abuse Disease Management Initiative,
- TANF Referrals,
- Transitional Age Youth,
- The Guardianship Project,
- The Department of Mental Health Veterans Projects,
- Peer Specialists in the Veteran's Administration,
- Trauma Awareness & Becoming Trauma Responsive Training,
- Access Crisis Intervention,
- SAMHSA Policy Academy and Veteran Mapping,
- SSI/SSDI Outreach, Access and Recovery: A SAMHSA Technical Assistance Grant Effort in Missouri,
- An Introduction to Wellness Coaching,

- FY 2014-2015 Block Grant Behavioral Health State Plan,
- The Department of Mental Health Strategic Directions,
- Youth Mental Health First Aid, and
- FY 2012 Uniform Reporting System.

The SAC-CPS meets monthly and the SAC-ADA meets every other month.

3. **Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.**

Missouri's State Advisory Councils (SAC) on Alcohol and Drug Abuse (ADA) and on Comprehensive Psychiatric Services (CPS) were both involved in the development of the State Block Grant Plan. State staff began preparing a draft State Plan in October 2012. The draft was reviewed at a joint session of the ADA-SAC and CPS-SAC in December 2012. Based on recommendations received, a revised draft was distributed to the SAC's in March 2013 with a second review in April 2013.

4. **Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?**

Missouri has two separate planning councils: State Advisory Council on Alcohol and Drug Abuse (SAC-ADA) and a State Advisory Council on Comprehensive Psychiatric Services (SAC-CPS). The SAC-ADA focuses on substance abuse prevention and treatment. The focus of the SAC-CPS is on children and youth with serious emotional disorders and adults with mental illness and their families. The SAC-ADA and the SAC-CPS meet in joint sessions as needed to coordinate recommendations on behavioral health services including co-occurring disorder services. The SAC-ADA and the SAC-CPS met in joint session to make recommendations for Missouri's FY 2014-2015 Behavioral Health Assessment and Plan.

5. **Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?**

The SAC-ADA is currently comprised of 11 males and 10 females. Representation is obtained from each of the five planning regions: 4 from Central, 6 from Eastern, 4 from Southeastern, 3 from Western, and 4 from Southwestern. Nine of the 21 members (43%) are of minority racial or ethnic groups including African-American and Hispanic. About 19 percent of Missouri's general population is of a minority racial or ethnic group.

The SAC-CPS is currently comprised of 13 males and 10 females. Representation is obtained from the four regions: 5 from Eastern, 3 from Central, 1 from Western, 4 from Southern, and 8 with statewide representation. Three of the 23 members (13%) are of minority racial or ethnic groups. About 19 percent of Missouri's general population is of a minority racial or ethnic group.

6. **Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.**

Missouri has two separate planning councils: State Advisory Council on Alcohol and Drug Abuse (SAC-ADA) and a State Advisory Council on Comprehensive Psychiatric Services (SAC-CPS). As specified in state statute, the functions and duties of the SAC-ADA are to:

1) Promote meetings and programs for the discussion of reducing the debilitating effects of alcohol or drug abuse and disseminate information in cooperation with any other department, agency or entity on the prevention, evaluation, care, treatment and rehabilitation for persons affected by alcohol or drug abuse;
2) Study and review current prevention, evaluation, care, treatment and rehabilitation technologies and recommend appropriate preparation, training, retraining and distribution of manpower and its resources in the provision of services to persons affected by alcohol or drug abuse through private and public residential facilities, day programs and other specialized services;
3) Recommend what specific methods, means and procedures should be adopted to improve and upgrade the alcohol and drug abuse service delivery system for citizens of this state;
4) Participate in developing and disseminating criteria and standards to qualify alcohol and drug abuse residential facilities, day programs and other specialized services in this state for funding by the department (RSMO 631.020).

Current SAC-ADA membership is comprised of 6 members who are individuals in recovery and 15 members who are employees of state agencies, providers, or academia. Collectively, these individuals provide a diverse perspective on the prevention and treatment of substance abuse. SAC-ADA meetings include updates, presentations, and discussions from the Division of Behavioral Health (DBH) Director and/or his representative and section heads from prevention, treatment, and fiscal units. In addition, the SAC-ADA receives regular briefings and feedback from the Missouri Recovery Network, which is a statewide organization advocating for addiction treatment and recovery support. Membership includes individuals in recovery, family members, friends, allies, and other supportive people. The SAC-ADA also receives regular briefings from the Missouri Substance Abuse Professional Credentialing Board on matters pertaining to professional credentialing and workforce development. The SAC-ADA meets in joint sessions with the SAC-CPS as needed to coordinate recommendations on behavioral health services, including recommendations for Missouri's FY 2014-2015 Behavioral Health Assessment and Plan.

Current SAC-CPS membership includes 9 members who are individuals in recovery from mental illness, 2 family members of individuals in recovery, and 8 members who are employees of state agencies, providers, or academia. The SAC-CPS has the following duties:

1) Review State plans and submit any recommended modifications to DBH;
2) Serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems;
3) Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

The SAC-CPS serves as an advocate for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illness or emotional problems. SAC-CPS advocacy activities include promoting the Consumer/Family/Youth Conference; Peer Specialist training and certification; and coordinating Hands across Missouri – an annual,

consumer-run event sponsored by the SAC-CPS, the Missouri Mental Health Foundation, and local organizations. The SAC-CPS continues to support Peer Specialist training and certification. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. With the oversight of the SAC-CPS, Peer Specialist Basic Trainings have been conducted since 2008. Twenty Community Mental Health Centers, 10 Consumer Operated Services Program Drop-In Centers and Warm-Lines, the Veteran's Administration, Services for Independent Living, and substance abuse treatment agencies have sent individuals to training. Three of the state operated inpatient facilities have active Certified Missouri Peer Specialists on staff.

Real Voice Real Choices is the annual consumer conference to educate, inform, and empower individuals in treatment and/or recovery and their families. This conference developed from Missouri's Mental Health Transformation Grant, a SAMHSA-funded grant that ended in 2011. The 2013 Conference was held in August at Lake of the Ozarks. Session topics included wellness, recovery from hoarding/collecting, guardianship, crisis intervention, use of technology in recovery, smoking cessation, companion dogs, relationships in recovery, housing options for individuals in recovery, laughter exercises, building a career, suicide prevention, understanding disability benefits, and finding a voice. The SAC-CPS has a subcommittee who plans and coordinates this conference.

Both the SAC-ADA and the SAC-CPS promote the Missouri's Mental Health Champions – an effort to recognize the accomplishments of individuals whose lives have been challenged by mental illness, substance abuse, and/or developmental disabilities. The 2013 Mental Health Champion awards ceremony and banquet was held in May at the Capitol Plaza Hotel in Jefferson City.

Missouri Department of Mental Health
State Advisory Councils For
Comprehensive Psychiatric Services
and Alcohol and Drug Abuse

July 25, 2013

Grants Management Officer
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Rd, Room 7-1091
Rockville, MD 20850

Dear Grants Management Officer:

The State Advisory Councils for the Missouri Department of Mental Health, Division of Behavioral Health, (formerly the Division of Comprehensive Psychiatric Services and Division of Alcohol and Drug Abuse) have reviewed the State Plan for the FY 2014-2015 joint Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant Application. Both State Advisory Councils are committed to working with the department to create a recovery oriented system of care.

In 2012 the State Advisory Council for the Division of Comprehensive Psychiatric Services held two joint meetings with the State Advisory Council for the Division of Alcohol and Drug to create a unified understanding of a statewide seamless advisory support system to the Division. The two primary objectives for the joint council meetings in 2012 were to collaboratively assist the Division of Behavioral Health in its efforts to prepare policy and implement services to Missourians challenged with mental health and/or substance abuse issues and to review, with recommendations, the Department's State Plan for the FY2014 - 2015 Block Grant Application. After several review sessions with both bodies of the perspective advisory councils and staff assigned by the Division, both Councils approve of the State Plan, written under our guidance.

We will continue to work with the Division of Behavioral Health staff in monitoring the implementation of the State Plan. We appreciate our involvement in the Block Grant development and would like to express appreciation to SAMHSA for making these funds available.

Sincerely,

Mickie McDowell, Chair
CPS State Advisory Council

Ladell Flowers, Chair
ADA State Advisory Council

The Department of Mental Health does not deny employment or services because of race, sex. creed, marital status, national origin, disability or age of applicants or employees.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year: 2014

End Year: 2015

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Barbara Anderson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5577 Connecticut St. Louis, MO 63139 PH: 314-781-5492	BKanderson2@att.net
Bruce Charles	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2715 Chestnut Hannibal, MO 63401 PH: 573-541-2715	Bruce.Charles28@yahoo.com
Stewart Chase	Providers		ReDiscover, 901 NE Independence Avenue Lee's Summit, MO 64086 PH: 816-246-8000 FAX: 816-246-8207	sachase@rediscovermh.org
Mariann Atwell	State Employees	Department of Social Services/Medicaid	Department of Social Services/Medicaid, P.O. Box 6500 Jefferson City, MO 65102 PH: 573-522-8336	mariann.atwell@dss.mo.gov
Heather Cushing	Family Members of Individuals in Recovery (to include family members of adults with SMI)		114 Distinction Lake St. Louis, MO 63367 PH: 314-608-1206	hjcushing@gmail.com
Sarah Earll	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		St. Louis Empowerment Center/Heartland Consumer Network, 1908 Olive St. Louis, MO 63103 PH: 314-652-6100 FAX: 314-652-6103	ssearll@sbcglobal.net
Betty Farley	Providers		Missouri Protection and Advocacy Services, 925 South Country Club Drive Jefferson City, MO 65109 PH: 573-659-0678 FAX: 573-893-4231	Betty.Farley@mo-pa.org
Scott Giovanetti	State Employees		Department of Mental Health, 5400 Arsenal Street St. Louis, MO 63139 PH: 314-877-0372 FAX: 314-877-0392	scott.giovanetti@dmh.mo.gov
Andrew Greening	Providers		Preferred Family Healthcare, 4355 Paris Gravel Road Hannibal, MO 63401 PH: 573-248-3811 FAX: 573-248-3080	agreening@pfh.org
Liz Hagar-Mace	State Employees	State Housing Authority	State Housing Agency, 1706 East Elm Street Jefferson City, MO 65102 PH: 573-522-6519 FAX: 573-526-7797	liz.hagar-mace@dmh.mo.gov

John Harper	State Employees	Dept. of Elementary & Sec. Educ./Div. of Voc. Rehab.	3024 Dupont Circle Jefferson City, MO 65101 PH: 573-526-7049 FAX: 573-751-1441	john.harper@vr.dese.mo.gov
Robert Hawkins	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		43 Catamaran Drive Lake St. Louis, MO 63367 PH: 636-575-1913	bobhawkins08@yahoo.com
Jessica Johnson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4000 Hyde Park Avenue, Apt. 29 Columbia, MO 65201 PH: 417-343-1634	jessicacjohnson22@gmail.com
Toni Jordan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3640 Garfield Avenue St. Louis, MO 63113 PH: 314-531-0511	Jordan.toni@ymail.com
Gregory Markway	State Employees	State Criminal Justice Agency	2729 Plaza Drive Jefferson City, MO 65102 PH: 573-526-6523 FAX: 573-526-8156	greg.markway@doc.mo.gov
Glenda Meachum-Cain	State Employees		Missouri Dept. of Health and Senior Services, 912 Wildwood Drive Jefferson City, MO 65102 PH: 573-526-8534	Glenda.Meachum-Cain@health.mo.gov
Mickie McDowell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3324 South Avenue Springfield, MO 65807 PH: 417-895-1332	mickie.mcdowell@gmail.com
Rene Murph	Family Members of Individuals in Recovery (to include family members of adults with SMI)		9822 Edgefield Drive St. Louis, MO 63136 PH: 314-246-7774 FAX: 314-963-6132	murphr@webster.edu
Robert Qualls	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1465 E. Hwy PP Bolivar, MO 65613 PH: 417-253-2246	robert-qualls@sbcglobal.net
Jerome Riley	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1234 W. Cape Rock Dr. Apt. 31 Cape Girardeau, MO 63701 PH: 573-339-8725	jriley@cccntr.com
John Robbins	State Employees	State Education Authority	205 Jefferson Jefferson City, MO 65102 PH: 573-522-1488 FAX: 573-526-4261	john.robbins@dese.mo.gov
Tish Thomas	Leading State Experts		University of Missouri, 1706 East Elm Jefferson City, MO 65102 PH: 573-751-8076 FAX: 573-751-7815	tish.thomas@dmh.mo.gov
Karah Waddle	Providers	Preferred Family Healthcare	900 E LaHarpe St Kirksville, MO 63501 PH: 660-665-1962	kwaddle@pfh.org
John Czuba	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		28963 Westwood Dr Macon, MO 63552 PH: 660-651-6462	johnczuba@hotmail.com
Benjamin Bruening	State Employees	Missouri National Guard	1225 Cooper Dr Jefferson City, MO 65101 PH: 573-638-9500	benjamin.t.bruening@us.army.mil

Cynthia Steuber	State Employees	Missouri Department of Corrections	PO Box 70 Fulton, MO 65251 PH: 573-592-4018	cindy.steuber@doc.mo.gov
Stephanie Washington	State Employees	Missouri Department of Health and Senior Services	930 Wildwood Dr, PO Box 570 Jefferson City, MO 65102 PH: 573-522-2550	stephanie.washington@health.mo.gov
Cheryl Gardine	Providers	Center for Life Solutions	637 Dunn Rd, Suite 180 Hazelwood, MO 63042 PH: 314-731-0100	cheryl@centerforlifesolutions.org
Nancy Johnson	Others (Not State employees or providers)	Cigna Healthcare	13045 Tesson Ferry Rd St. Louis, MO 63128 PH: 660-988-2090	nkr323@gmail.com
Diana Harris	State Employees	Missouri Department of Corrections	220 South Jefferson Ave St. Louis, MO 63103 PH: 314-982-8216	diana.harris@doc.mo.gov
Percy Menzies	Providers	Assisted Recovery Centers of America	Chippewa St, Suite 224 St. Louis, MO 63109 PH: 314-645-6840	percymenzies@araamidwest.com
Thomas Casey	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		9041 McKnight Woods Richmond Heights, MO 63117 PH: 314-421-0763	tjc@caseydevon.com
Clif Johnson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Southeast Missouri Behavioral Health	512 East Main St, PO Box 506 Park Hills, MO 63601 PH: 573-431-0554	cjohnson@semobh.org
Phillip Britt	State Employees	35th Judicial Circuit Treatment Courts	PO Box 805 Kennett, MO 63857 PH: 573-888-6882	phillip.britt@courts.mo.gov
Sandra Jackson	Others (Not State employees or providers)	John J Pershing Veteran's Administration	1500 N Westwood Blvd Poplar Bluff, MO 63901 PH: 573-778-4740	sandra.jackson2@va.gov
Kelly McKerrow	Others (Not State employees or providers)		2 Lakeside Dr. Perryville, MO 63775 PH: 573-513-9880	kellymckerrow@gmail.com
Ladell Flowers	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Dismas House of Kansas City Inc.	301 E Armour Blvd Kansas City, MO 64111 PH: 816-531-6050	flowers@dismashousekc.com
Robin Hammond	Others (Not State employees or providers)	St. Joseph Youth Alliance	5223 Mitchell Ave. St. Joseph, MO 64507 PH: 816-232-0050	rhammond@youth-alliance.org
Dave Brown	Others (Not State employees or providers)	Missouri Western State University	4525 Downs Dr. St. Joseph, MO 64507 PH: 816-271-4327	brownday@missouriwestern.edu
Michael Carter	State Employees	Missouri Department of Health and Senior Services	149 Park Centeral Sq, Suite 116 Springfield, MO 65806 PH: 417-895-6968	mike.carter@dhss.mo.gov
Marilyn Gibson	State Employees	Circuit Court, 31st Judicial Circuit Court	1010 Boonville Ave Springfield, MO 65804 PH: 417-576-7637	marilyn.gibson@courts.mo.gov
Edgar Hagens	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		413 N Boonvilel Sprinfield, MO 65806 PH: 417-866-9717	rocks-hiphip@att.net
Susan Scott	Individuals in Recovery (to include adults with SMI who are receiving, or have		909 Kentucky Ave West Plains, MO 65775	scottsusan54@yahoo.com

	received, mental health services)	PH: 417-257-7480

Footnotes:

Missouri does not have a single Behavioral Health Advisory Council. There is a State Advisory Council for Alcohol and Drug Abuse and another State Advisory Council for Comprehensive Psychiatric Services. The Councils meet periodically in joint session as needed.

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year: 2014

End Year: 2015

Type of Membership	Number	Percentage
Total Membership	44	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	15	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	1	
Others (Not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	23	52.27%
State Employees	14	
Providers	6	
Federally Recognized Tribe Representatives	0	
Vacancies	1	
Total State Employees & Providers	21	47.73%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	10	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	12	
Persons in recovery from or providing treatment for or advocating for substance abuse services	23	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Missouri's State Advisory Councils (SAC) on Alcohol and Drug Abuse (ADA) and on Comprehensive Psychiatric Services (CPS) were both involved in the development of the State Block Grant Plan. State staff began preparing a draft State Plan in October 2012. The draft was reviewed at a joint session of the ADA-SAC and CPS-SAC in December 2012. Based on recommendations received, a revised draft was distributed to the SAC's in March 2013 with a second review in April 2013. The SAC's provided approval to the State Plan in July 2013.

Footnotes:

Missouri does not have a single Behavioral Health Advisory Council. There is a State Advisory Council for Alcohol and Drug Abuse and another State Advisory Council for Comprehensive Psychiatric Services. The Councils meet periodically in joint session as needed.

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

Enrollment and Provider Business Practices, Including Billing Systems

Missouri will opt out of the three percent set-aside option.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

Y Comment on the State BG Plan

In accordance with Section 1941 of the Block Grant legislation, the State of Missouri provides ongoing opportunity for the public to comment on the State Plan. The State posts its Block Grant State Plan and Reports on its public website: http://dmh.mo.gov/ada/rpts/blockgrant.htm and http://dmh.mo.gov/mentalillness/blockgrant/index.htm. These posts are accompanied by statements soliciting public comment:

Substance Abuse: *The Substance Abuse Prevention and Treatment (SAPT) Block Grant application provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64) as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively). Part of the mission of the Center for Substance Abuse Treatment (CSAT) is to assist States and communities to improve activities and services provided with funds from the SAPT Block Grant. The information gathered for the application can help States describe and analyze sub-state needs. This data can also be used to report to the State legislature and other State and local organizations. Aggregated together, statistical data from States' applications can demonstrate to Congress the magnitude of the national substance abuse problem. This information will also provide Congress with a better understanding of funding needs. The SAPT Block Grant Application is prepared and submitted annually to the Center for Substance Abuse Treatment (CSAT) by the Missouri Department of Mental Health, Division of Behavioral Health (DBH), formerly the Divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services. The application is a requirement for receiving Missouri's portion of the SAPT Block Grant, a major source of DBH funding. The SAPT application includes a state plan that describes how SAPT funds will be used. Includes the federal fiscal year (FFY) 2004-2011 applications.*

The CSAT requires each state to have a process to facilitate public comment in developing the plan and the application for Block Grant funds. The Division encourages interested persons to review the application and submit comments and suggestions that can be considered for inclusion in the next Block Grant application submission.

Please mail your comments to: Director, Division of Behavioral Health; P.O. Box 687; Jefferson City, MO 65102. You can also e-mail your comments to: ***adamail@dmh.mo.gov****.*

Mental Health*: Section 1941 of the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Community Mental Health Services Block Grant stipulates that the State will provide opportunity for the public to comment on the Block Grant. Please send any comments on the Mental Health Services Block Grant to rosie.anderson-harper@dmh.mo.gov.*

The State Plan was reviewed by a joint session of the State's Planning Councils for Mental Health and Substance Abuse at their open meeting held in December 2012. Comments and suggestions were considered and incorporated into the plan where applicable. A revised State Plan was distributed in February 2012 with a subsequent review by the Councils during March and April. In addition, Block Grant informational presentations are made periodically to orientate new members and to discuss ongoing or emerging issues pertaining to the Block Grants. The State's Planning Councils have direct access to the Department and Division

Directors, at meetings and by phone/email, to offer opinions and comments on the adequacy of behavioral health services within the State. Meeting agendas and minutes are posted to the public website.